Taking Culture into Account in the Fight against HIV/AIDS

A Literature Review of Gender and Sexuality in South East Africa

Thesis submitted in partial fulfillment of the requirements for the Degree of

Master of Philosophy in Culture, Environment and Sustainability

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September 2005

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Acknowledgements

First and foremost I would like to thank my supervisor Jennifer Schirmer for her enthusiasm as well as motivational and theoretical guidance throughout the implementation of this Master thesis.

Second, I acknowledge and thank my best friend Morten who contributed from the very beginning with constructive ideas and criticism, who made me late dinners after long hours at SUM, who told me that I could do this, and who kept putting and pushing me back on track.

I am also very grateful for the support, the discussions, the good working environment and the fun provided by my fellow Master students at Sognsveien 70. –I will truly miss you.

Many people at SUM have contributed in the process of selecting, defining and developing my research topic as well as giving technical assistance and encouragement along the way, and I would like to thank Peder Anker, Alida Jay Boye, Hans-Jørgen Christiansen, Gitte Egenberg, Bente Herstad, Desmond McNeill, Yassin Dahillion Mohamoda, Hakim Moradi, Kristoffer Ring, Endre Stiansen, Terje Tvedt and Nina Witoszek for any assistance and for every encouraging smile. I would also like to thank Rune Flikke at the Institute of Social Anthropology who willingly shared his knowledge and experience from Southern Africa with me.

Finally I wish to thank everybody who has read parts of or my entire thesis for their time and for valuable feedback, everybody who has encouraged me and believed in me through the entire process and Obaid for putting pressure on me by continuously keeping up to date on my progress.

List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal clinic
et al	et alii (and others)
FAO	United Nations' Food and Agriculture Organization
HIV	Human Immunodeficiency Virus
MUTAN	Mradi wa UKIMWI Tanzania na Norway (a Tanzania- Norwegian HIV/AIDS project)
NACP	National AIDS control programme
NGO	Non governmental organization
s.a.	sine anno (without year)
Sida	Swedish International Development Cooperation Agency
STD	Sexually transmitted disease
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
WFP	World Food Programme
WHO	World Health Organization

Chapter 1

Introduction

1.1 The Aim and Outline of this Thesis

> [S]ubstantial social science research has been conducted on HIV/AIDS during the last 20 years. There are of course research gaps, but much is already known. We know what kinds of socio-economic contexts are driving the pandemic (in which poverty and gender inequality are the main forces) and that an interplay of factors are facilitating sexual transmission. Among these factors are: little or no condom use; a large proportion of an adult population with multiple partners; overlapping (as opposed to serial) sexual partnerships; wide sexual networks (often due to work migration); women's economic dependence on marriage or poverty driven commercial sex work and their lack of power in negotiating sexual relationships; age differences between sexual partners - typically older men and young women or girls; high rates of sexually transmitted infections, especially genital ulcers. At the same time research shows that most people in Africa have a good knowledge about AIDS.
>
> (Freudenthal 2001)

This Master thesis attempts to draw attention to cultural factors that are facilitating the spread of HIV/AIDS in South East Africa. Medical research is being conducted on antiretroviral drugs that decelerate the body's virus production as well as on vaccines to prevent infection, but a worldwide vaccination programme is still far into the future (HIV Norge 2005). The conviction lying behind this thesis is that we, humankind collectively, can not win the fight against HIV/AIDS by medical treatment alone; we need to halt the spread of this pandemic. To achieve that goal, it is my position that the international community needs to increase awareness and obtain behavioural change by taking culture into account in the war on HIV/AIDS.

Dr Piot, Executive Director of UNAIDS, argues that the health sector can not alone bring the epidemic under control, and he asks for a broad engagement of all sectors and people of all walks of life, including people living with HIV/AIDS and religious leaders, in order

to halt the spread of HIV and AIDS (2004). While depending on international cooperation Stephen Lewis, UN Secretary-General's Special Envoy for HIV/AIDS in Africa, gave an optimistic statement after visiting four Southern African countries in December 2002. He claimed that:

> …there is no question that the pandemic can be defeated. No matter how terrible the scourge of AIDS, no matter how limited the capacity to respond, no matter how devastating the human toll, it is absolutely certain that the pandemic can be turned around with a joint and herculean effort between the African countries themselves and the international community. (Lewis 2003: 2nd paragraph)

He argues further that "[w]hat is required is a combination of political will and resources. The political will is increasingly there; the money is not" (Lewis 2003: 4th paragraph). However, interestingly, viewed in the light of this thesis, culture is not mentioned. Political will is necessary, no doubt about that, but the argument behind this thesis is that without taking culture into account all the campaigns and will of political leaders, as well as the work of development aid agencies, to win the war on HIV/AIDS are, unfortunately, likely to keep failing. Millions are put into prevention campaigns, but very little is put into understanding the cultural basis for how people perceive HIV and the obstacles to HIV prevention. At the same time we know that lack of knowledge can no longer elucidate the sustained spread.[1]

The authors of *The social and cultural contexts of HIV/AIDS transmission in the Kagera Region, Tanzania* state that "Change in sexual behaviour seems to be the only reliable method of controlling the further spread of HIV" (Lugalla et al 1999: 377). They continue describing sexual behaviour as "shaped by a variety of social and cultural factors inherent in the society" (Lugalla et al 1999: 377). The argument of this thesis is that local cultural belief systems need to be taken into account, including cultural beliefs as to how "good sex" is defined. These topics need to be understood by foreign and local development aid personnel and medical staff alike, as well as the people of South East Africa. The thesis also illustrates that the Western belief in science and presentation of medical facts and statistics has proved itself to be insufficient to change behaviour. Cultural belief systems are by their nature complex, and to halt the spread of HIV in this worst hit region of the

[1] See quote from Freudenthal 2001at page 1.

world, we need to look beyond statistics and take into account the cultural constructions of life ways in this region.[2]

Map 1 South East Africa (Hoge 2002)

I have chosen to look at seven African countries: Kenya, Malawi, Mozambique, Tanzania, Uganda, Zambia and Zimbabwe. These countries are interesting due to their extremely high HIV prevalence rates, and the fact that they are all neighbours in Eastern and Southern Africa (see Map 1). Furthermore, there are no rigid groupings of countries into the regions called "East Africa" and "Southern Africa", and some of these countries will easily slide into either category while others are distinctively Eastern or Southern African countries. I refer to this selected group of countries as "South East Africa". Some of the authors referred to in this thesis have made other definitions and groupings, and when referring to them I will follow their definitions, without always pointing them out.

[2] We are here also dealing with a second belief system brought into Africa with colonialism; Christianity and more specifically Catholicism, placed on top of the traditional belief systems of South East Africa. That dichotomy is important to acknowledge as religion is strong in this region.

However, some of these seven countries are always included when the terms “East/ Eastern Africa” or “Southern Africa” are used in this thesis. The same applies to the terms “Africa” and “Sub Saharan Africa” if any particular countries within those regions are mentioned by name in the literature referred to. The countries of Botswana and South Africa which border my selected region are even worse hit by the HIV/AIDS epidemic, but South Africa is so different from the rest of the region and Botswana especially is so hard hit that the two are cases needing separate individual studies.

South East Africa contains a wide variety of cultures, with Uganda being one of the most heterogeneous countries in the world.[3] However, many authors also refer to Africa, Sub Saharan Africa, Southern Africa or East Africa as unities, and in those cases I also refer to them as such. It is therefore important to note that the findings I present do not necessarily serve as representative of all cultures and all societies, urban and rural, in the region at large. Rather, the studies with a wide geographical scope as well as the area-specific ones, serve as mere representations of individual, numerous cultures within the larger region.

This thesis represents a collection and examination of existing literature, chiefly ethnographic studies, on the relation between culture and HIV-transmission and prevention in South East Africa, with a lengthy bibliography for further perusal. Such a collection of the literature and research already conducted can enable us to identify researchers’ interpretations of cultural traits which are facilitating the spread of HIV in South East Africa. It can next provide us with a better understanding as to why prevention campaigns in many instances have failed or been insufficient. Such an examination of the literature furthermore helps us identify cultural phenomena, especially surrounding sexual beliefs and practices, which are essential to acknowledge in order to improve the achievements of the global community in the further fight towards terminating the spread of HIV in this vast region.

Due to the large quantities of existing literature on HIV/AIDS, I have had to limit my topic to a few related issues concerning gender relations and sexual practices. As a consequence, I omit the entire topics of men who have sex with men and the gendered reality of the military and their interactions with civilian women. I have also left the issues

[3] See among others Ugandatourism 2005

of displacement and refugee situations for another time, recognising that rape of the enemy's women has been used as a weapon in many wars and conflicts and that women are six times more likely to become HIV infected while living in refugee camps than they would otherwise (Thime 2000). Writing on Zimbabwe, Kvam and Eskildsen (2002) point out that traditionally men have several sexual partners, and this is a practice encouraged by labour migration. Men often work away from home for up to a year, with many visiting prostitutes from whom they get infected; they then later bring the virus home with them to their wives and girlfriends. However, due to limitations of the thesis, the issues of labour migration and prostitution per se have barely been touched upon.

As for the structure of this thesis, I will start with a presentation of HIV and AIDS. Next I will introduce my own methodology and emphasize some considerations about research in general and on the sensitive issue of sexuality in particular in Chapter 2. In Chapters 3 and 4, I will give a brief introduction to the concept of culture and to the South East African context within which HIV is spread. Finally, in Chapter 5, I move on to the presentation of the literature I have studied on certain cultural factors which are facilitating the spread of HIV in South East Africa.

While concentrating on culture, I hold that the cultural factors highlighted in my literature overview cannot be fully understood apart from their context. Much of the literature I have studied also treat topics belonging in the chapter on the South East African Context, as well as in the literature overview. Hence, I start introducing the authors and the literature already in Chapter 4.

1.2 HIV and AIDS

HIV stands for *Human Immunodeficiency Virus*. HIV is a retrovirus infecting cells of the human immune system and it destroys or impairs their function. An infection leads to a progressive depletion of the immune system and finally immune deficiency. Immunodeficient people have an increased vulnerability to a wide range of infections which are mostly rare among people without immune deficiency. No symptoms develop immediately after the infection and hence most people infected with HIV do not know that they have been infected. An HIV-infected person, even without any symptoms, is however

highly infectious and can transmit the virus to another person. HIV infection leads to AIDS which stands for *Acquired Immunodeficiency Syndrome* (UNAIDS 2004a, 2005a).

According to UNAIDS the first cases of AIDS were discovered in the United States in 1981.[4] Then a number of unusual immune system failures were identified among gay men and in 1982 AIDS was first defined. Blood transfusions, sexual intercourse, injecting drug use and mother-to-child transmission were identified as modes of transmission[5] and in 1983/84 the Human Immunodeficiency Virus was identified as the source of AIDS (UNAIDS 2004a).

1.2.1 Epidemiology

Globally the number of people living with HIV keeps growing. The estimate for 2001 was 35 million while it in 2003 had grown to 38 million. This included almost 5 million people infected in 2003,[6] a higher number of new infections than any previous year. In 2004 nearly 40 million people were estimated to be living with HIV. 30 million people have already died of AIDS (UNAIDS 2004c, 2004d, 2005b).

UNAIDS' statistics show that Sub Saharan Africa has just over 10 % of the world's population, but is home to more than 60 % of all people living with HIV. In 2004 an estimated 25.4 million people were living with HIV in Sub Saharan Africa and of the nearly 3 million AIDS deaths globally in 2003, 2.2 million (or 75 %) were in Sub Saharan Africa. Among young people aged 15-24 an estimated 6.9 % of women and 2.2 % of men were living with HIV at the end of 2004 (UNAIDS 2004c, 2005c).

[4] Some sources believe in earlier cases, e.g. Court (2004) present it as likely that HIV was present in Uganda already during the late 1970s.

[5] As the only source I have found, an article from the International Journal of STD & AIDS challenge the conventional hypothesis that sexual transmission is responsible for more than 90 % of adult HIV infections in Africa. Gisselquist et al (2002) here refer to many studies reporting HIV infections in African adults with no sexual exposure to HIV and in children with HIV-negative mothers. Their hypothesis is that HIV transmission through unsafe medical care may be an important factor in the current HIV epidemic in Africa, arguing that differences in sexual behaviour across countries do not explain the differences in epidemic trajectories. A somewhat horrifying fact presented is that HIV can survive in a syringe at room temperature for more than four weeks. The team of authors concludes that there is a serious possibility that "an important portion of HIV transmission in Africa may occur through unsafe injections and other unsterile medical procedures" (Gisselquist et al 2002: 663).

[6] From the 2003 number are subtracted all who have died of HIV/AIDS between 2001 and 2003

Over the past few years the HIV prevalence rates in Sub Saharan Africa have stabilized but because of population growth the actual number of people infected continues to grow. The stabilization of prevalence rates is due to increasing AIDS deaths together with continuing high numbers of new infections. In 2004 an estimated 3.1 million people became newly infected while 2.3 million died of AIDS in Sub Saharan Africa (UNAIDS 2004c, 2005c).

The prevalence rates vary considerably between my selected South East African countries, and also between different regions within each country. The worst hit country within my sample is Zimbabwe with an adult (15 to 49 years) prevalence rate of 24.6 %, while Uganda, which is known as the success story in Sub Saharan Africa when it comes to halting the spread of HIV, was down to 4.1 % at the end of 2003. While 4.1 % may come across as a small number, it does in fact represent some five hundred thousand individuals. This is a substantial number, indeed far from satisfactory. Information on HIV prevalence among antenatal clinic (ANC) attendees shows the significant differences within countries. According to numbers from Kenya in 2002 that prevalence was on average 14.3 % in urban areas and 6.3 % outside urban areas, based on numbers ranging from 4 to 35 percent (UNAIDS/WHO 2004).

In his statement at the Humanitarian Forum, Norwegian Red Cross, 19 April 2004, Dr Piot (2004), pointed out that Sub Saharan Africa is the epicentre of the global epidemic. In the six Southern African countries Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe “the AIDS epidemic is overwhelming the coping resources of entire communities and fuelling a widening and increasing deadly famine” (Piot 2004: 10). Out of the twenty-six million people living in these six countries over 5 million adults and 600 000 children under the age of 15 are living with HIV/AIDS (Piot 2004: 10).

Another statistic which draws a not too bright picture for the future of South East African HIV prevention, except for the fact that there is a major potential for improvement, is the basis for Valy’s article on Mozambique: On average men in Sub Saharan Africa have access to about three condoms a year (Valy 2004).

Writing on Malawi, Lwanda (2004) reveals that in 1994 only 43 % of the country’s state health facilities and 11 % of the mother and child outreach services provided family

planning services. By 1997 only 21 % of the women asked in a study of condom use among urban workers and their wives had ever used condoms.

In nine African countries, including Malawi, Mozambique, Zambia and Zimbabwe, life expectancy at birth has dropped below 40 years, much due to HIV/AIDS, and in 2003 life expectancy at birth in Zimbabwe was 34 years compared to 52 years in 1990 (UNAIDS 2005c).

In a thematic document for the 2000 African Development Forum it is furthermore pointed out that Africa is the continent least well-placed to respond to the crisis of HIV/AIDS. Being the poorest continent, Africa has the worst health and educational infrastructure and the weakest civil society. The document also emphasises that the political leaderships in many African countries are marked by patrimonialism, corruption, authoritarianism and even militarization and criminalization. In addition, Africa is subject to a high degree of disruption, with mass displacement due to war and disaster, and mass migration in search of employment and opportunity. This rupture makes the governments and civil society even less capable of handling the epidemic and the population even more vulnerable to infection.

Chapter 2

Methodology

My sources are mainly qualitative studies. According to Thagaard (2002), the goal of qualitative texts is to give the reader a coherent understanding of and insight into the social phenomena studied and described. What I will do here is present the methodological specifics of this thesis as well as more general methodological challenges of doing research on sensitive issues and foreign cultures, before I move on to the theoretical framework and my focus on South East Africa.

2.1 What I Have Done

I have chosen to look at literature on perceptions and behaviour of gender and sexuality in South East Africa published from 1995 to 2004.[7] I do also have some references from 2005 but these are newspaper articles and statistical material only. Obviously, neither local cultures nor people's perceptions and knowledge of HIV/AIDS have been constant during these ten years, but I have chosen to look at the literature within my sample independent of when it was written or published and rather focused on the cultural factors discussed and presented in it. I have not distinguished between books, journal articles, theses, reports or other written work, not between published printed works and Internet based material, nor between foreign and African authors. The only limitations present have been what I have physically been able to find through library and Internet searches, as well as the use of the bibliographies of literature found, in addition to the language in which the literature is written. The literature presented in the literature overview is written in English and Danish and consists of 11 books, 14 articles, 6 reports, 4 theses and one thematic pamphlet. Rather than writing a traditional literature review with thorough

[7] Included in this sample of literature are records of research done as far back as the early 1990s.

analysis of the material I have tried to give an unbiased presentation and an overview of the existing literature on certain categories of cultural factors which are facilitating the spread of HIV in South East Africa.

I did also meet with Rune Flikke, Dr Polit and associate professor of the Institute of Social Anthropology at the University of Oslo with a specialization in Southern Africa, to discuss the epidemiological history of Southern Africa and the context in which to view the present epidemic of HIV/AIDS. This meeting took place January 24, 2005.

2.2 Methodological Challenges

The following section will address some methodological challenges faced by researchers in general and the authors referred to in this literature overview in particular. I will also discuss some of my own challenges in conveying independent literature into a thematic overview.

There are many difficulties attached to research on the matters I am addressing in this thesis and many of the authors included in the literature review are dealing with quite sensitive issues. Themes related to sexuality may be taboo to talk about, hence one might not get any answers at all, or the answers one does get may not reflect a truthfulness. In some societies, having many sexual partners is high status, while in others the norm is to be monogamous, and in both cases the digit one gets when asking about number of sexual partners might not be the actual one. When interviewed many people, consciously or not, answer the questions posed in a manner they perceive the interviewer to want, simply saying what they believe the other person wants to hear.

In her introductory book in qualitative methods, Thagaard (2002) points out that in research where informants have shown high degrees of openness and sincerity about their situation it is important not to violate that trust and honesty by exposing them and their identity to the readers. Ensuring the respect and consideration for the informants might, however, in some cases come in conflict with the accuracy of the research presented and the expectations of the research community as to how the results of research should be presented. If the researcher gives a critical presentation, informants may feel exposed or experience the presentation of the results as an attack. Smaller communities can be quite

transparent, and even when no names are mentioned people may know who the researcher talked to. Respondents may also feel exposed, without anybody knowing their identity, just by experiencing parts of their private life being brought public. Hence the presentation or the process of being researched itself may have negative outcomes for the informant, which violates the ethic guidelines of research activity, and is ideally circumvented. The opposite position may however also be problematic. In much of the literature I have read, and present here, the study object is marginalized groups or individuals. In such cases the researcher may feel it important to present the information in a way favourable to the informants and hence promote their case. Ideally, a researcher should be able to be understanding of the informants' situation without acting as their spokesperson, but researchers are only human and real objectivity is hard to achieve. The ethical responsibility also implies that the researcher is able to communicate comprehensiveness and nuances in the material (Thagaard 2002). In addition, some might also question the ethics of and perceive it condescending to describe people's misconceptions without providing any possible or likely explanations or sources for these beliefs.

Thagaard further addresses the methodological challenges faced by an overview literature search that many of the texts describing social and cultural phenomena may be coloured by the researcher's own interpretation of the local culture, especially if the author has little training in cultural contexts and meanings. Informal experience surrounding the exchange of data, knowledge, beliefs and as personal experiences may also influence conclusions. Thus the text may to a certain degree represent a constructed depiction of such cultural realities. Researchers may create stories about a particular person's social life and, based on that, construct an entire social world of cultural meanings and behaviours. Because the researcher's interpretations are mirrored in the text, the text and the reality are by the reader perceived as closely interwoven. The stories are interpretations, and hence they should not be taken to be constructions only; they are images and representations of reality, whereas not necessarily the only possible ones (Thagaard 2002).[8]

Hellevik (2002) argues that also when it comes to the choice of research topic, the position of the researcher himself or herself is of importance. A researcher's value base will to

[8] Positivists present an alternative and contradictory view of the qualitative text. This perspective claims that a text can be detached from the actuality it describes and it is emphasized that the phenomena described in the text can also be detached from the researcher's interpretation of those phenomena. (Thagaard 2002)

some extent influence the choice of problem to investigate, the formulation of the research question and the analysis and presentation of the findings. The researcher's frame of reference is particularly important relating to what he or she interprets as problematic and hence interesting to study in a community.

There may also be difficulties related to presenting findings of sexual behaviour which differ from the norms of the receivers. Doing research on people's norms and values is a sensitive matter, and there may be political controversy about the findings. Different groups have different agendas, and one has to be very careful when presenting aspects of somebody's culture that may or are believed to have negative consequences. For foreign researchers, writing on Africa may also include a concern of duplicating colonial legacy. Judging a culture other than one's own is a sensitive subject. Practices that appear risky for somebody from outside a community may be very logical to local people and for behavioural change to occur it has to make sense to the people concerned (Lwanda 2004). To claim that a culture needs to change its basic norms or value systems is very serious, and besides, some norms may be perceived so valuable in and of themselves that to keep them is actually worth losing some additional individuals to HIV and AIDS. Such a valuation may also be linked to the innate fatalism in this region, making people highlight seizing the day.[9]

My motivation for writing about HIV in Sub Saharan Africa is my general awareness and sincere concern about the extent and consequences of this epidemic and the deterioration of economic development and communities of the region. I have my agenda, and my different sources as well as my potential readers may have others. What I have read are interpretations and while reading, summarizing and categorizing the literature I make my own interpretations based on and coloured by what I consciously or unconsciously am looking for in the texts as well as my prior knowledge and readings.

Kluckhohn (1949) points out that our morality starts from different assumptions, and that two actions which look virtually identical may have very different meanings depending on the context and the culture in which they take place. A lack of knowledge of significance for understanding the behaviour of individuals can easily result in misunderstandings and

[9] See also Section 5.8 Fatalism

misinterpretations. I am in no position to argue or presuppose what people actually mean or believe, let alone why, nor am I by any means qualified to make judgments of such behaviour, belief or value. While a European, like me, may see HIV infection as the worst possible scenario, an African may see HIV infection as only one of a multitude of mortal diseases one is likely to catch[10]. Based on such varying approaches, the reasons for and interest in preventing the spread of HIV is likely to differ. Yet, for me personally, to halt the spread of HIV is essential, and for that to come about, it may be that some cultural, sexual and religious practices, in South East Africa and elsewhere, will have to change.

[10] See also Sections 3.1 Perception of Risk and 5.8 Fatalism

Chapter 3

The Importance of Culture in Fighting HIV/AIDS

There exists a multitude of definitions and descriptions of the concept of culture, and the ones I present here all address some central aspects of my interpretation of both what culture is and what culture does.

Writing a thesis in the 21st century, I obviously start my search at the World Wide Web. The Internet based dictionary of the English language *dictionary.com* starts its explanation of the word *culture* as "The totality of socially transmitted behavior patterns, arts, beliefs, institutions, and all other products of human work and thought". For the purpose of this thesis I limit my focus on the very first part of that sentence, the totality of socially transmitted behaviour patterns.

Moving on to more traditional literature on the concept of culture, I find Kluckhohn who argues that "Culture regulates our lives at every turn. From the moment we are born until we die there is, whether we are conscious of it or not, constant pressure upon us to follow certain types of behaviour that other men have created for us" (Kluckhohn 1949: 26). Accordingly, the world we are born into is already defined by cultural patterns. He explains further that "A culture is learned by individuals as the result of belonging to some particular group, and it constitutes that part of learned behaviour which is shared with others" (Kluckhohn 1949: 26). At the same time, he claims that "Most groups elaborate certain aspects of their culture far beyond maximum utility or survival value. In other words, not all culture promotes physical survival" (Kluckhohn 1949: 27). This might be a controversial proclamation, but the literature I will present in the following chapters in large part substantiate Kluckhohn's statement.

The Washington State University's Baseline definition of culture highlights the fact that people *learn* culture as culture's essential feature:

> Culture, as a body of learned behaviors common to a given human society, acts rather like a template (ie. it has predictable form and content), shaping behavior and consciousness within a human society from generation to generation. So culture resides in all learned behavior *and* in some shaping template or consciousness prior to behavior as well (that is, a "cultural template" can be in place prior to the birth of an individual person). (Baseline Definition [s.a.])

The culture which is to be learned does however not appear in the form of a text-book with a constant enduring content. Culture is constantly changing and this is a second significance to take into account when giving culture its appropriate attention. The existence of HIV in a community may in turn influence not only people's perception of HIV itself, but also how people see other aspects of life, hence the culture is changing. An example of this influence, which I will examine later, is fatalism. While fatalism is an inherent part of life in many South East African communities, the presence of HIV and AIDS can easily strengthen this vision as people see their friends and family dying of AIDS without having any ability to impede its advancement.

Susan Sontag introduces another aspect of culture being learned in her essays *Illness as Metaphor* and *AIDS and its metaphors*. She presents metaphors as responses to diseases which are not understood; mysterious diseases which have no cure. Writing about cancer she argues that cultural myths about the illness tended to isolate and estrange cancer patients (1991). These myths or metaphors are cultural constructions, passed on within and between communities, taught and learned. With HIV/AIDS today, such cultural metaphors may prevent people from getting tested or seeking treatment due to fear of social stigma; social stigma which is already making life worse for those living with a publicly known HIV/AIDS infection. The literature presented in Chapter 5 will also illustrate that learned approaches and perceptions in South East Africa are not always the interpretations most beneficial to public health. It also shows, as the case was with cancer, that cultural beliefs and practices may make people question what is presented as scientific evidence, the scientific cure or the scientific method of prevention. In the West, it took quite a while from cigarette smoking being connected to cancer was presented as a scientific fact, throughout public health campaigns, before the linkage was considered common knowledge and smoking in some countries was ruled illegal in pubs and public

places. With sexuality and the prevention of HIV/AIDS the transformation of beliefs and behaviour is even more difficult, hence likely to take longer, as people's sexuality is so sensitive and intimate, so central to ones identity and ones sense of self.

Culture can be seen as the context within which we live, and one of the matters I am trying to highlight with my thesis is that single elements in a culture cannot be fully understood without being viewed in relation to and in consideration of other cultural elements surrounding it. Kluckhohn furthermore argues that cultural features may serve as preserving continuity with the past, making certain sectors of life familiar and predictable (Kluckhohn 1949). A similar approach is used by Alfred Kroeber who compares culture to a coral reef where new corals build on their deceased relatives. Like the coral reef, culture is different from and exceeds the sum of its parts and its form is gradually developed often without the actors' self awareness of it happening (Eriksen 1998). Moreover, people are not always conscious about where their own attitudes and belief systems come from nor the implications these can have on their own as well as their loved ones' health.

The Mexico Declaration on Cultural Policy of 1982 proposed the following definition of culture which is still widely used and referred to today:

> …culture may now be said to be the whole complex of distinctive spiritual, material, intellectual and emotional features that characterize a society or social group. It includes not only the arts and letters, but also modes of life, the fundamental rights of the human being, values systems, traditions and beliefs (UNESCO 1982: 41)

On the basis of this definition UNESCO holds culture to include ways of life, traditions and beliefs, representations of health and disease, perceptions of life and death, sexual norms and practices, power and gender relations, family structure, languages and means of communication as well as art and creativity. Hence culture is important in relation to HIV/AIDS because it influences people's attitudes and behaviours (UNESCO 2002). To be able to change people's behaviour in the fight against HIV/AIDS, UNESCO argues for culture to be taken into account at various levels:

- as context – an environment in which HIV/AIDS communication and prevention education takes place;
- as **content** – local cultural values and resources that can influence prevention education; culturally appropriate content of sensitization messages is mandatory for them to be well understood and received

- and as a **methode** that enable peoples' participation, which helps to ensure that HIV/AIDS prevention and care is embedded in local cultural contexts in a stimulating and accessible way. (UNESCO 2002: last paragraph)

Geertz state that "man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs" (Geertz 1973: 5). This will also be my interpretation. What I see as culture, borrowed from Clyde Klukhohn's *Mirror of Man,* is a people's way of thinking, feeling, and believing and their learned behaviour. A set of values, beliefs and behaviours.

Kluckhohn also addresses the concept of cultural relativity. He states that "The concept of culture, like any other piece of knowledge, can be abused and misinterpreted" (Kluckhohn 1949: 41), pointing at the fear of cultural relativity weakening morality through promoting an attitude of somebody else's actions legitimising ones own. His statement is however also valid in the sense of justification and legitimization of harmful practices; it is their culture and hence we can not condemn it. He also points at the principle of cultural relativity of seeing customs in a context and the need to evaluate these habits with regard to how they fit in with other group habits (Kluckhohn 1949).

On their web-pages on a baseline definition of culture the Washington State University introduces another aspect of culture which is also important in understanding the bigger picture of South East African culture:

> To the extent that culture consists of "the learned behaviors of a given human society," women and men figure equally in the cultural system. However, the cultural "template" [….] is constantly being negotiated, revised, and reproduced, and the power to participate in this process of negotiation has historically been divided along gendered lines. (Women, Culture and Power [s.a.])

Historically most dominant world cultures have been patrilineal, and most cultures to some degree still are today, in the developed as well as the developing world. The power of women is limited as women are still under-represented politically, they are paid less than men for equal work, in many major religions women are restricted from access to positions of authority, and family descent is most often traced through the father (Women, Culture and Power [s.a.]; Pratt 2002).

In an introduction to their cultural approach to HIV/AIDS prevention and care UNESCO state that

> Health has always been an essential component of development policies. In this domain, as in others, culture has a fundamental role to play. Conceptions of health and disease, and related beliefs, traditional practices and the use of medicinal plants: these are all essential variables to be taken into account when building sustainable development policies. (UNESCO 2002: 1)

Summarizing the previous, culture is what gives meaning to people's lives and it is the basis for how we behave. Relating this to the battle against HIV/AIDS, people's understanding of what "good sex" and "acceptable sex" is, and whether or not condoms can be a part of such sex is linked to and is in part a result of people's cultural belief systems. Important to note however is that men traditionally are the ones to define "good sex" and many women may even never have experienced such a thing. Rather, what men define as "good sex" is for them what is experienced as "expected sex".

As culture helps people make sense of daily life, it is my argument that to fight the spread of HIV in South East Africa these belief systems need to be better understood. Hence culture should be approached as part of the solution, rather than part of the problem. Culture is often seen separate from economic, social and political factors, but in fact it includes all of these, and I will address those subjects briefly in Chapter 4. Furthermore, as an example of this close connection, I will show in the following that women's vulnerability is intertwined with the cultural practice of them being brought up to be submissive and being taught that men are to be dominant, while men learn to *be* dominant.[11]

Culture is at the basis of how people make sense of HIV and of life. It is at the heart of what perception is all about, including people's perception of risk. Our culture in large part defines what we believe to be right or wrong, how we make sense of what disease is about and how we include sources of information and make it part of our knowledge of life. That is why incorporating culture into HIV works is so important.

3.1 Perception of Risk

In her work on risk acceptability Mary Douglas writes about perception of risk that

[11] Related to this is also the notion of "culture" as a feminine, and hence less valued, expression contrasting the more "masculine" subjects of "politics" and "economy".

> …individuals have a strong but unjustified sense of subjective immunity. In very familiar activities there is a tendency to minimize the probability of bad outcomes. Apparently, people underestimate risks which are supposed to be under their control. They reckon they can cope with familiar situations. They also underestimate risks of events which are rarely expected to happen. (Douglas 1985: 29)

Douglas's starting point is the public perception of risks of new technologies, but some of her perspectives are just as relevant when it comes to perceptions of risk of HIV infection. Based on risk perception as treated in the various social sciences Douglas argues that

> Most common everyday dangers tend to be ignored. On the other end of the scale of probabilities, the most infrequent, low-probability dangers also tend to be played down. Putting these tendencies together, the individual seems to cut off his perception of highly probable risks so that his immediate world seems to be safer than it is and, as he also cuts off his interest in low-probability events, distant dangers also fade. (Douglas 1985: 30)

These tendencies work together with the individual's level of knowledge. What you know about an event or a threat will always be important for your conscious or unconscious determination and final perception of risk. In relation to the possibility of contracting HIV both knowledge about physiological susceptibility and statistical likelihood, as well as attitudes towards the consequences of getting infected, are important for one's perception of risk. If one do not perceive catching a fatal disease to constitute a particular threat because of one's thoughts and beliefs about life and death, then what I in this thesis refer to as unprotected or risky sex might not be perceived risky at all.

In their critical review of Douglas' cultural theory Oltedal et al point out that people can not face every risk, nor can they avoid being exposed to potentially hazardous risk sources. They agree that we do not always rate the most risky activities as more dangerous than less risky ones, as our risk judgments are unlikely to be entirely rational and our subjective risk judgments, i.e. the perceived risk, may differ from "objective" risk. "Objective" risk is here defined as "the risk that exists independent of an individual's knowledge and worries of the source of the risk" (Oltedal et al 2004: 11). They argue further that humans are influenced by their surroundings and that the environment affects cognition as well as behaviour and individual decisions and that people learn to believe that the standards, principles, perspectives and explanations we acquire from our culture

are the way to look at the world (Oltedal et al 2004). Hence, our culture to a significant degree constitutes our mind set, including our perception of risk.

Both "objective" risk and people's interpretation of risk affect their perception of both the probability of an occurrence and the consequences of that event actually happening. One's perception thus depends on how one weighs the two, consciously or not, and the conclusion also in part depends on one's accuracy of knowledge about the particular conditions. "Perceived risk" again determines how a person understands and experiences a phenomenon. Many factors may influence our perceptions of risk, and Oltedal et al, in line with Douglas' work, mention familiarity with the source of danger, control over the situation and the dramatic character of the event, as people tend to overestimate rare, striking events and underestimate the frequency of common events (Oltedal et al 2004).

People's first perception of risk resembles their intuitive risk judgments. In the book *The Perception of Risk* Paul Slovic points out that sociological and anthropological studies have shown that perception and acceptance of risk have their roots in social and cultural factors. While the sociologist Short argues that response to hazards is mediated by social influences transmitted by friends, family, fellow workers and respected public officials, the anthropologists Douglas and Wildavsky state that people, acting within social groups, downplay certain risks and emphasize others as a means of maintaining and controlling the group (Slovic 2000). Downplaying certain risks can be carried out as a way of preserving the present way of life, while emphasizing other risks may bring about the creation a common enemy.

Writing on a set of mental strategies that people use to make sense of an uncertain world Slovic explains that

> [R]esearch on basic perceptions and cognitions has shown that difficulties in understanding probabilistic processes, biased media coverage, misleading personal experiences, and the anxieties generated by life's gambles cause uncertainty to be denied, risks to be misjudged (sometimes overestimated and sometimes underestimated) and judgments of fact to be held with unwarranted confidence. (Slovic 2000: 221-222)

Referring to further research he argues that because perceptions influence the way subsequent information is interpreted, people's perceptions are resistant to change and

should not be expected “to evaporate” (Slovic 2000: 222) when confronted with something presented as evidence:

> New evidence appears reliable and informative if it is consistent with one’s initial beliefs; contrary evidence tends to be dismissed as unreliable, erroneous or unrepresentative […]. When people lack strong prior opinions, the opposite situation exists – they are at the mercy of the problem formulation. Presenting the same information about risk in different ways (eg, mortality rates as opposed to survival rates) alters people’s perspectives and actions […]. (Slovic 2000: 222)

This statement substantiates my quest for anti HIV/AIDS campaigns to take cultural beliefs into account. To be able to achieve a change of behaviour information must be presented in a way both relevant and convincing to its audience.

Chapter 4

The South East African Context

This chapter will give a brief introduction to the South East African context. Here I will present a number of topics which act as a framework for the cultural beliefs and practices to be presented in the literature overview. This is to give a better understanding of life in South East Africa and the challenge and complexity of combating HIV/AIDS and achieving a sustainable development in this region.

4.1 History

Like any other region or continent, also Africa's history is influenced by economic and political, as well as environmental, social and cultural practices and processes. Furthermore, history itself is also important to understand the present situation for the people living here, as well as the economy, politics and cultures of today. Barraclough (1997) points out that in early African history the north developed in close association with western Asia while Africa south of the equator, due to the desiccation of the Sahara, was cut off from any considerable contact with the outside world for centuries. In his opinion this isolation was an important factor in the cultural development of the region.

In newer history the effects of the extensive slave trade can not be disregarded. Between 1450 and 1870 some 15 million human beings were shipped out of Africa, and the effects on the continent for its further development are hard to quantify, but nonetheless substantial. In addition, the loss of people was not evenly distributed and some regions and countries suffered disproportionately while others benefited from the trade (Barraclough 1997).

Then of course European imperialism and the colonization of Africa with its inherent drain of resources can not be left out of an analysis of the present situation. Flikke (2005) points out that large areas of Africa were depopulated as a result of European epidemics imported during the colonial era. Disease and suffering spread fast and became an important factor in the development and legitimation of African colonialism. The responsibility for the suffering was given its victims, which consequently appeared to be causing their own suffering. Thus they were in desperate need of help and development brought to them from outside. The depopulation also threatened development due to a general shortage of people to sustain livelihood, as large areas were actually under-populated.

African culture also evolved in the encounter with European culture. To understand what people in the industrialized world perceive to be a denial of medical facts one might look at African explanations like the ones Flikke present in his article on European epidemics in Africa in a historical context. He refers to young African men arguing that first the West took their land, their wealth and their jobs, and now we are taking away their dignity. With unemployment up to fifty percent among African men, frustration is immense and as one of the last things they have left to enjoy, many now feel a threat and an attempt of the West to take away their sexuality. Many people in Africa have developed an intuitive scepticism to rules and norms forced upon them, as experience and history show every reason to be sceptic (Flikke 2005; Flikke private conversation January 24, 2005). The 2002 Dictionary of Human Geography furthermore explains how culture historically has been used as a term of human difference and as a strategy of differentiation. The colonial perspective communicated was in part to present non-European peoples who differed from the westerners as having not only different, but implicitly also inferior cultures (Cosgrove 2002).

4.2 Politics

Thime (2000) argues that the most important reason for AIDS having become an epidemic is national authorities lacking the ability and willingness to really address the existence of HIV/AIDS. She highlights that the apparent success of Uganda can be traced to its authorities acknowledging HIV/AIDS as a problem and a challenge at an early stage of the

epidemic, and then setting out to fight it. Uganda chose a strategy of openness and an open debate about the problems. Unfortunately many countries still do not admit to the problems, and some not even to the existence, of HIV/AIDS. Piot also points out that "Because it [HIV/AIDS] preys on the most private human behaviour and stays invisible for years, it has silenced us from acting" (Piot 2004: 15).

In 1999 Malloch Brown, the Administrator of the United Nations Development Programme (UNDP), declared that we can not expect any hard hit developing country to succeed their fight against HIV/AIDS without considerable assistance from the wealthier nations. He referred to the situation as a development crisis which requires extensive achievements from a broad spectre of partners, including governments, non-governmental organizations (NGOs) and the private sector (Thime 2000).

As early as 1949 Kluckhohn stated that "Since every culture has organization as well as content, administrators and lawmakers should know that one cannot isolate a custom to abolish or modify it" (Kluckhohn 1949: 41). If a part of everyday life is suddenly forbidden, people will find a way around it. The existence of a polygamous mentality in African cultures is an example of this. Where polygamy is outlawed, men typically keep many partners in stead of many wives.

4.3 Education

High levels of illiteracy and absence of basic education in much of South East Africa are major obstacles in the fight against HIV/AIDS. With education come not only knowledge but also the ability to acquire knowledge, as well as some degree of socialization and interaction with, and opportunity for seeking out, potential sources of information. Poverty and the lack of education available to women are facilitating the spread of HIV as this lack of opportunity reinforces women's subordinate position and puts them at risk of early marriages and pregnancies, while strengthening the dominant position of males (UNESCO/ UNAIDS 1999).

Poverty, which I will return to shortly, influence not only individuals' possibility of getting an education, whether parents can afford to send their children to school or if their labour is needed to maintain the family economy; The poverty of a nation also limits its

ability to provide education and information. To build and maintain an educational sector is costly and requires a financial foundation which many developing countries can not provide. Much of the same basis is needed for developing and distributing information campaigns. Knowledge does not come for free, and besides, educating a population requires an infrastructure which many developing countries do not have.

4.4 HIV/AIDS and the Collapse of Social and Cultural Life

The spread of HIV represents both an emergency requiring urgent action and a development challenge requiring sustained commitments over the long term, as HIV/AIDS is capable of destroying the economic and social structures of entire countries (Piot 2004). Thus, HIV/AIDS is not only a health problem; it is a general and very serious development matter.[12]

Giving an introduction to HIV/AIDS's impact on society Loewenson and Whiteside write:

> HIV will have a strong impact on social development, organization and culture. […] The negative impact will include the loss of key people at household and organizational level who play important roles in those units (parents in socialization of children, elected leaders, people with experience and so on) while placing increasing stress on the survivors. The demoralization and potential to become fatalistic about death can affect all levels of society, from household to national level. Stress in social systems such as education and health can undermine social development at all levels that may have a long-term impact on society. Economic stress has in itself created pressure on households that have been reported to increase marital instability and domestic violence and to undermine social cohesion. (1997: 30)

Among the infected aged 15-49 in Africa, the proportion of women is reaching 60 %, and being the main care-givers and source of household labour, women's illness often means the collapse of family structures and community care networks. When the main financial supporter is the one who is ill, women's increased focus on care giving can lead to a labour shortage in the planting, weeding and fertilizing of crops, which in many places are

[12] See also Freudenthal 2001

women's tasks, thus having a negative impact on the harvest. This in turn may threaten the family's food supply as well as sales income (Loewenson and Whiteside 1997).[13]

In addition, the rate of illness and death due to AIDS among service providers has a major negative impact on the capacity of the state and private sector to deliver services, thereby jeopardizing development (Piot 2004). According to the United Nations' Food and Agriculture Organization (FAO) a study found that in Sub Saharan Africa up to fifty percent of agricultural extension staff time was lost through HIV/AIDS. In Kenya's Ministry of Agriculture, fifty eight percent of all staff deaths are caused by AIDS, and in the first ten months of 1998, Zambia lost 1300 teachers to AIDS, a number which equals around two thirds of all new teachers trained annually. In some regions in African the authorities educate two teachers to ensure that at least one of them will be able to start working, and this is critical also because of the importance of education to improve knowledge about HIV/AIDS and reduce risky behaviour. The drop in life expectancy also implies a decreased number of years of employment and an increased pressure on the educational institutions caused by more frequent recruitment procedures and the general lack of qualified people to take the available jobs. In addition, HIV-positive employees may not be able to sustain their normal work load while still employed, due to symptoms of their illness (FAO [s.a.] b; Thime 2000).

In her 2001 review of social science research on HIV/AIDS prepared for the Swedish International Development Cooperation Agency (Sida) Freudenthal argues that

> The disaster caused by HIV/AIDS is unique because it deprives families, communities and entire nations of people at their most productive ages. The epidemic is deepening poverty, reversing human development achievements, worsening gender inequalities, eroding the ability of governments to maintain essential services, reducing labour productivity and supply and hampering economic growth in the countries worst affected for decades to come. (2001: Introduction)

Likewise Loewenson and Whiteside point out that "As it [HIV/AIDS] is far more than a health issue, it may reverse the development gains of the past decades" (Loewenson and Whiteside 1997: 4). HIV/AIDS hits the adult and productive part of the population the hardest and the people who fall ill and die are the parents and leaders in society. This

[13] See also Section 4.4.2 Food and agriculture in the time of AIDS

leaves an entire generation of children in shortage of the care and role models they would normally have. (Loewenson and Whiteside 1997) By 2001 the number of AIDS orphans had reached 14 million worldwide (UNAIDS 2004e), and Thime (2000) refers to a UNAIDS estimate predicting a rise to 40 million by 2020 in the 23 hardest hit countries alone. In Mozambique, Zambia and Zimbabwe (and in 8 other Sub Saharan African countries) more than 16 percent of children were orphaned by 2001 (UNAIDS 2004e).

FAO draws an even bigger picture, declaring that "the epidemic is undermining the progress made in the last 40 years of agriculture and rural development". (FAO [s.a.] a: last paragraph) The organization also points out the problem of people in rural areas dying before being able to pass on their knowledge and expertise of agricultural production to the next generation (FAO [s.a.] b).

HIV/AIDS also adds direct economic challenges for communities through increased expenses to education and health. These are resources necessarily seconded from other services; hence achievements in other areas will be affected.

4.4.1 Poverty, Gender Inequality and HIV/AIDS

Poverty can not be disregarded in the comprehension of any part of society in South East Africa, and it is at the basis of the current spread of HIV. Kvam and Eskildsen (2002) present AIDS as a problem of poverty, as poor people are easily forced into situations of high HIV risk. They give the example of women selling sex as their only way to finance food for their children, pointing out that in such a situation why should, or how can, one worry about a disease that might kill them in ten years, when the alternative is to starve to death some day soon.[14] Yet, poverty and sexuality are gender-determined matters and Forman (1997) argues that while wealth allows men to have many sexual partners, poverty can force women into the same situation.

Poverty makes people, and especially women, more vulnerable to engage in risky behaviour like commercial sex, hence it becomes a co-factor in the acceleration of vulnerability and susceptibility of HIV transmission (Kyakuwa 2002). Furthermore,

[14] See also Rweyemamu 1999

poverty and HIV are mutually reinforcing as poverty forces people to engage in risky behaviour and HIV pushes people into poverty (Traditional culture 2004).

Writing on Uganda, also Nossum points out that poverty is a major hindrance for women's safer sex choices. She points at low literacy and a high rate of drop-out from school among girls meaning little access to information about how to protect oneself against HIV. Sexually transmitted infections are widespread in Uganda, making people even more vulnerable to HIV transmission. While adult men are better informed than adult women in Uganda, it is men who are both biologically and socially more likely to pass the virus on. Nossum also explains how HIV/AIDS creates a vicious circle as parents get sick and die, forcing children, chiefly the female ones, to leave school, which further increases their vulnerability (Nossum 2002).

Umerah-Udezulu's essay offers gender-based public policy perspectives on the spread of HIV/AIDS among African women. Leaving the issue of gender aside, she states that "Due to sub-standard health care systems and lack of economic and political stability, the developing countries are the hardest hit by the AIDS crisis" (Umerah-Udezulu 2001: 2). Here she eliminates the importance of culture, but later in the essay she moves on to a discussion of gender inequality, which is essential in my interpretation of culture in Africa.

4.4.2 Food and Agriculture in the Time of AIDS

Food shortage and malnutrition are two additional issues of critical importance in the fight against HIV/AIDS and, moreover, the two are mutually reinforcing. Nutritious food can prolong the lives of those infected and give them the opportunity to keep working, bring home employment income and keep supporting their families. Healthy nutrition contributes to maintain the immune system, and people suffering from malnutrition are generally more vulnerable to infectious diseases, plus their recovery is harder. HIV also aggravates the effects of malnutrition through reducing the appetite and interfering with digestion and the body's mechanisms for utilizing nourishment. Hunger may also drive HIV negative persons into risky survival strategies, like prostitution, and hence boost their

vulnerability to HIV infection (Jong-wook and Morris 2005; World Food Programme 2004a).

The World Food Programme (WFP) (2004b) also points out that for HIV infected people proper nutrition contribute to a better response to medical treatment as well as maintenance of strength and energy level, again making them able to keep working, take care of their family and generally live a better life. In accordance with FAO also the WFP calls attention to the fact that in many households where one or more family members are HIV infected, children are forced to leave school because the families are no longer able to pay for their education, or because the children need to work in order to support their families or take responsibilities as care givers.

At the same time HIV/AIDS causes deterioration of food supply and the nutritional situation. Piot (2004) introduces the weakness of agricultural production due to AIDS as a contributing factor to southern Africa's food crisis in 2003, in the way that AIDS have made communities unable to cope with cyclical bad seasons which they might have handled in the past.

The young productive members of community, the ones the families depend on as breadwinners and providers, dominate the statistics of new HIV infections, and the food supply is undermined by the need to care for sick family members and relatives. The family members' productive labour is re-allocated, taking time away from employment and agricultural work and gathering in favour of caretaking, hence more potential providers are lost while the number of dependants grows. The cost of HIV/AIDS medication may also blast family economies, as may funeral expenses (World Food Programme 2004a; Food and Agriculture Organization (FAO) [s.a.] a, [s.a.] b). Loewenson and Whiteside (1997) also point out that in addition to reduced remittances, farm inputs and family labour, the death of the adult worker may lead to reduced access to land, housing and assets, reduced schooling and shifts from cash to subsistence crops.[15] In many countries a large segment of the population is employed in the agricultural sector, and labour-intensive farming accounts for more than one third of the gross national product in many African countries (Lamptey et al 2003).

[15] See also Lamptey et al 2003

The Food and Agriculture Organization reveals that contrary to conventional wisdom, throughout the developing world AIDS is becoming a greater threat in rural areas than in cities. Due to increased contact between rural and urban areas through trade, migration and improved transportation networks HIV prevalence rates rise faster in rural areas, and in absolute numbers, more people are living with HIV in rural areas. Rural communities also carry a higher burden when it comes to caring for the ill, as many migrant workers and people residing in urban areas return to their home villages when they fall ill. Furthermore, access to information and health services are scarcer in rural areas than in cities, adding to the problem of many girls being taken out of school to help at home due to the increased burden of caring for the sick and dying (FAO [s.a.] a, [s.a.] b).

4.5 Sexually Transmitted Diseases

In Akeroyd (1996) the linkages between sexually transmitted diseases (STDs) and HIV are presented as being of critical importance, as both ulcerative and non-ulcerative STDs are facilitate the transmission of HIV, and the prevalence rates for STDs in Africa are "extremely high" (Akeroyd 1996: 45).

Klepp, Biswalo and Talle (1995) present the example of Tanzania. In addition to being biologically more susceptible to HIV infection than men, women in Tanzania also have a higher rate of other untreated STDs, which makes them even more at risk of contracting HIV. According to Baylies (2000) untreated STDs can increase the probability of HIV transmission in both men and women by as much as ten times, and because women often show no symptoms of their STDs they are less likely to be treated. Also Webb (1997) points at the problem of women often failing to recognize symptoms, and he argues that even if they do acknowledge symptoms, many African women are reluctant to visit formal medical services for treatment.

STDs are a general health-problem in much of Africa. They also cause infertility and still-birth, which again can be a factor in marriage break-ups forcing women into adopting sexual survival strategies. Writing on Eastern and Southern Africa, Akeroyd reveal that, apparently, for men STDs are a sign of manhood and a proof of many sexual partners, while for women STDs are a matter of shame and a reminder of their powerlessness in relation to men (Akeroyd 1996).

Chapter 5

HIV/AIDS, Gender Inequality and Cultural Perceptions and Behaviour of Sexuality: A Literature Overview

I have conducted an extensive literature overview regarding the social and cultural reality of sexuality and gender roles in HIV/AIDS-infected societies in South East Africa; societies characterized by male dominance, female subordination and economic marginalization. In these societies men's identities are considerably linked to their sexuality and their control over women while women's identities are fundamentally rooted in their traditional roles as mothers and wives.[16] Women's number one sexual and ultimate priority appears to be to "please their men". In a situation of economic decline, gross unemployment and a weakening of all social structures and cultural traditions, many men perceive themselves as having lost their traditional dominant position. As a result, sexuality has for many become the one situation they feel they can control, including having control over somebody beyond themselves.

It is imperative that the fight against HIV in South East Africa be seen within this context of a traditional submission of women to men and their long-suffering compliance to men's dominance, in which many women have had, and still have, no control over their own lives and bodies. In addition to their dependence in both sexual and economic terms on men, women are also physiologically more vulnerable to HIV than men. Baylies (2000) explains:

[16] See among others Nossum 2002; Traditional culture 2004

> All else being equal, the probability of male to female transmission is estimated to be two to four times that of female to male transmission […]. The reasons are higher concentrations of HIV in semen than in vaginal fluid, a larger area of exposed female than male genital surface area, greater permeability of the mucous membranes of the vagina compared with those of the penis, and longer period of exposure of semen within the vaginal tract. (Baylies 2000: 5)

In the Strategy Note for the 2004 World AIDS Campaign on Women, Girls, HIV and AIDS, UNAIDS states that young women and girls make up sixty-four percent of people aged 15-24 living with HIV or AIDS. In Sub Saharan Africa girls and young women are twice as likely to be HIV-infected as young men, with up to six times the infection rate of their male counterparts in parts of the sub-region. In parts of Eastern and Southern Africa more than one-third of teenage girls are HIV infected (UNAIDS 2004d: 4).

According to the social norms, girls are expected to be passive and ignorant in relation to sex, while boys are encouraged to be sexually active and have multiple partners. This leaves decisions of condom use to boys, with many still deeply reluctant to use them. Sex is often a taboo subject, and sex education and general knowledge about one's own body and reproduction is minimum, with most young people ignorant of, or indifferent to, the risks. Culturally, girls who do have knowledge about their own sexuality and try to protect themselves against HIV infection are at risk of being stigmatized as "bad girls" (UNAIDS 2004b).

Akeroyd (1996) points at too little attention paid to the topics of sexual practices, sexual and reproductive health and violent or coerced sex in the pre 1996 HIV/AIDS literature from Africa. Based on my findings, a general acknowledgement of the importance of these issues is yet to come, but topics of gender inequality and sexual belief systems and behaviour are present in literature, even if not yet to a satisfactory degree taken into account in politics and information and prevention campaigns.

5.1 Taking Culture into Account: Belief Systems vs. "Facts"

UNESCO/ UNAIDS' report "A cultural approach to HIV/AIDS prevention and care" from Zimbabwe revealed that even though knowledge and belief about HIV/AIDS was quite high among the sample population, only 52.5 % of the respondents perceived

themselves to be at risk of HIV infection, while 95 % stated a fear of AIDS. Condom use was tolerated or accepted by 87.5 % of respondents, and condoms appear to be available, but 75 % felt that women have no capacity to compel condom use, whilst 62.5 % said that women could not refuse sex in a relationship (UNESCO/ UNAIDS 1999: 7-11).

5.1.1 Belief Systems

In Ocholla-Ayayo's work from Kenya (1997) many of the respondents had heard about AIDS, but the majority of them were not certain about what AIDS actually is, and not everybody could say for sure how HIV is transmitted. Suggested pathways of infection were through kissing, shaking hands, breathing a victim's air, mosquito bites and sharing glasses or dishes. The virus was believed to be brought to Kenya from outside by foreigners such as tourists and truck drivers, something which by way of sexual practices is partially true, but by singling out a few groups as potential sources of transmission, people are very likely to ignore the more common risks, thus unknowingly put themselves at considerable risk of transmission. This belief in victimization inflicted from outside is part of a large vision which relates to historical experiences. Some also believe AIDS to be imported in food, used clothes and medicines, hence making the preventive actions promoted by educational campaigns futile.

The lack of knowledge and the amount of misinformation is a general problem, exemplified by one woman in a Ugandan focus group saying that "Look, I know I have no AIDS, I am pregnant" (Obbo 1995: 83), having been told that HIV-positive mothers do not conceive. Another example from Uganda is a man stating no reason for using a condom since they according to him anyway are 99 % unreliable (Obbo 1995).

In Zambia sex is referred to as mixing bloods, a unification which should only take place within marriage, and successful reproduction is the result of a state of "one blood". AIDS is believed to be a result of mixing bloods in an unsanctified sexual union, implying that HIV can not be transmitted between spouses (Dover 2001).

Another widespread misconception among the Chiawa of Zambia is that monogamy equals safe sex, without recognising that both *mutual* monogamy and neither partner having acquired an HIV infection before entering into the monogamous relationship are

prerequisites for this to be true. Accurate knowledge of STDs/HIV among the young boys surveyed in Chiawa was mingled with misconceptions and less than accurate or plain incorrect information, and there were also variations in level of knowledge. The majority did not change to safer sex behaviour in spite of the basic knowledge they had, which is consistent with several other studies within Zambia and elsewhere, and Ndubani claims that researchers have been too optimistic about the role of knowledge in behavioural change. Behavioural changes in one area may influence on other aspects of life, and these changes may not be welcomed, for instance in cases where they oppose social norms (Ndubani 1998).

Rweyemamu, writing on sexual behaviour in Tanzania, quotes a bus driver stating that condoms are not safe because they are infected with the AIDS virus, and that is why he does not use them. The article does however not say anything about whether this is a common understanding or not. Other concerns presented relating to condoms and preventing their use were that wrongly worn they can cause friction and burst, they can get trapped inside women, condoms reduce sexual pleasure and buying condoms is for many synonymous with talking openly about sex, which is a taboo, therefore condoms are not displayed openly where they can be bought. There also exists a belief that masturbation is harmful and can make people mentally disturbed, a belief which eliminates such practice as an alternative to HIV-exposure. For some women, insisting on condom use is equivalent to saying “I am a prostitute”, which is a chance not to be taken because one must be careful not to anger one’s partner and financial supporter. Rweyemamu does however sum up by stating that there are signs of change, and young men have started to listen more to women who want to use condoms, or who refuses sex, than what has traditionally been the case (Rweyemamu 1999).

Pointing out inadequate health care systems and poor sex education as contributing factors to the spread of HIV, Umerah-Udezulu (2001) states that “Most people are still unaware as to how the disease spreads from one person to another” (Umerah-Udezulu 2001: 9). On the contrary, Hanne Østrem, a Norwegian missionary to Kenya for the last thirty-five years, claims that ninety to ninety-five percent of the population in Kenya now knows how HIV-infection is transmitted (Olsen 2005: 16).

Nossum (2002) argues that there is a disparity between young people's level of knowledge and the context in which they live. The knowledge is not contextualized to being relevant in their lives, making much of the information obtained an abstraction or a distant knowledge. Ndubani (1998) on the other hand argues that young people have a tendency not to fear AIDS. They somehow have an "illusion of invincibility" (Ndubani 1998: 55), and because they do not see themselves as vulnerable, behavioural change is difficult to achieve.

The issue of being misinformed keeps coming up,[17] indicating a strong link between cultural belief systems and sexual practices. These beliefs, more than anything, should serve as a starting point for development and health officials in order to distinguish how to make anti-AIDS campaigns more effective. Haram mentions a woman telling her that since her lover hated condoms they used Vaseline cream instead since "it reduces the risk of HIV transmission by at least 75 %" (Haram 1995: 43), whilst Baylies and Bujra (2000) present a belief that men get infected by having sex with a woman having had an abortion or a stillbirth, before she has had some menstruations for the blood to be clean. Kondowe and Mulera (1999) furthermore point out that many communities believe that HIV/AIDS can result from magic.

Setel's research in Tanzania found knowledge of AIDS and sexual transmission of HIV to be very widespread, and people fear it, but having the proper information and knowledge do not necessarily generate behavioural change. It seems that direct experience with AIDS has the greatest impact on behaviour. People see sex as their greatest entertainment, and their way of life is seriously affected by the existence of HIV. Men have had to limit their number of girlfriends and short-term relationships, and one man formulated his discontent like this: "Even with one girl, there is not much fun. You need to have several to have a good time. […] Life has become very miserable" (Setel 1995: 65).

Opposed to for example Umerah-Udezulu, Akwara, Madise and Hinde (2003) claim that ignorance is no longer an issue, however, in their view it is still unclear how perception of risk influences people's sexual behaviour. It appears that people often rationalize risky behaviour with socially constructed criteria that could explain what appears to be a

[17] See among others Foreman 1999; Lugalla et al 1999; Lwanda 2004; Ndubani 1998

mismatch between objective risk and perceived risk. AIDS is generally perceived a great threat, but not so much a personal one. People's perception of risk may also depend on how much they trust the accuracy of the information they are given. In 2000 UNAIDS pointed out that general awareness of AIDS was no longer important in AIDS prevention; what is important is accurate knowledge about how HIV is transmitted. A study of AIDS knowledge in Zimbabwe revealed that everybody questioned had heard of AIDS, but 15 % of men and 26 % of women did not believe that a healthy-looking person could carry the AIDS virus (Akwara, Madise and Hinde 2003: 392), hence they would be less likely to take precautions.

We see here somewhat contradictory reports of people's perception of risk. On the one hand there is simply little consciousness of risk, while on the other hand risk is perceived personal while not really understood. The belief that a person who looks healthy can not have HIV is not necessarily based on wrong information or misconceptions, but simply on people's experience of what it means to be ill. People think they know what disease looks like; if somebody is sick you can see it. However, contrary to every other known disease, being HIV-infected shows no evidence of illness at an early stage.

In their paper, Akwara, Madise and Hinde treat perception of risk as an explanatory variable for sexual behaviour. In 1998 28 % of women and 27 % of men in Kenya perceived themselves to be at no risk at all from HIV infection (Akwara, Madise and Hinde 2003: 395). It was revealed that teenagers tend to engage in unprotected sex. Sometimes there is a pressure for girls to prove their fertility before marriage and for boys to prove manhood by impregnating a girl or by having many sexual partners. The risk of HIV is high among young people, but it is often not perceived as high, which puts this particular age group further at risk (Akwara, Madise and Hinde 2003).

Baylies and Bujra (2000) explain that globally, half the new infections are among people aged 15-24. This is in part due to health services seldom being designed for the needs of youth. In many parts of Africa, traditional forms of sexual education, initiation ceremonies and teaching by older family members have lost their importance while new structures to carry out the task is lacking. Parents and children do not talk about sex, in part due to respect, and adolescents learn about sex from their peers, with the knowledge presented

not always being accurate. Premarital sex is also becoming more common among young girls, but without the proper education.

Furthermore, in Kenya and Tanzania some still do not recognise the existence of AIDS, or they believe that AIDS is temporary, like El Niño (Rugalema 2004), and Ndubani (1998) reports from Zambia that AIDS-related diseases are often attributed to witchcraft.

5.1.2 AIDS as Foreign

Until 1993 the belief among the Chagga in Moshi, Tanzania, was that AIDS existed elsewhere, and that there was no danger as long as one did not have sex with those returning ill with AIDS. This attitude diminished, but was not necessarily exchanged by a real concern. AIDS was linked to the change of local culture, a negative development towards promiscuity. The perception was that businessmen brought AIDS from cities, or from Kenya, with urban life and urban items perceived as dangerous, and the marked an area for transmission (Setel 1995).

In Kagera, far west in Tanzania, AIDS was first associated with traders, mobile young men and women and commerce, and at first the sexual transmission was not recognized, thus preventing people from protecting themselves. In the Kilimanjaro region AIDS was also related to business and for many poor smuggling was an important livelihood, with a source of HIV infection being female smugglers engaging in sex at the border not to be arrested (Setel, Lewis and Lyons 1999).

When research for Haram's chapter on the Meru women of Tanzania was done, most of those affected by AIDS had been outside Meru land and were therefore perceived different from the average and well-behaved Meru; they were young or middle-aged men or women who had transgressed Meru tradition, hence their infection could be traced to this violation (Haram 1995). Ocholla-Ayayo (1997) reports also older people in Kenya saying that those getting AIDS are people who violate cultural norms by engaging in premarital and/or extramarital sexual relations.

5.2 Sex as a Taboo

Writing on Uganda, Nossum (2002) points out that in many places sex is not a subject for open discussion.[18] The taboo is part of the cultural belief systems, and an important problem which Obbo (1995) mentions is the perception that there is no acceptable way to educate school children about AIDS because of the perceived danger of encouraging promiscuity. Obbo's representation of the voice of the young reveal that parents can not talk to young people about sex and condoms because these are taboo subjects which can not be touched upon without appearing to be promoting promiscuity, hence the young primarily learn from their peers. Piot on the other hand states that "Nothing spreads HIV faster than silence" (Piot 2004: 16), arguing for the need for every community to find its own language for addressing painful and sensitive issues central in the epidemic (Piot 2004).

In their work from 2002 Kvam and Eskildsen point out that very few HIV victims in Africa actually know that they are infected. It can take months or years after getting infected before any symptoms are visible and therefore neither the person carrying the virus nor the public may be aware of one's infection and infectiousness. People may thus have many sexual partners and transmit the HIV directly and indirectly to a large number of people before they even suspect their own infection. Many live far away from health facilities, most often one have to pay for the HIV-test, and there are anyway no drugs or treatment available, so there is little motivation for getting tested. If testing positive, one also faces the dangers of stigmatization, of getting expelled from family and community and of loosing one's job and home. This is in part because HIV/AIDS is associated with sex, in itself often being a taboo. Sex is a private concern and not spoken about. Since it is such a big risk to be open about one's HIV-infection, since HIV-infected face discrimination, many keep quiet, if they are even aware of their positive status themselves, and therefore condoms are rarely used and the virus is passed on to partners and often also from mother to child. According to UNAIDS (in Kvam and Eskildsen 2002) this silence is

[18] See also among others Aliro Ochieng; Fiedler 1999

one of the most important causes of the epidemic spreading at the current speed and extent (Kvam and Eskildsen 2002; Loewenson and Whiteside 1997).[19]

Williams, Milligan and Odemwingie claim that lack of accurate information is the most obvious obstacle to young people's sexual and reproductive health. This they argue is in part a consequence of the fact that most adults in Sub Saharan Africa (if it is valid to make such a generalization) believe that withholding information about sex from young people will discourage them from becoming sexually active at an early stage, however an interpretation which is discouraged by numerous research studies. In most parts of Sub Saharan Africa, sex is generally considered a taboo subject, and attempts to introduce sexual education in schools have been stopped by conservative opposition. Mass media and entertainment industries present degrading sexual images, and often actually give factually incorrect information about sex (Williams, Milligan and Odemwingie 2001).

Schoepf (1995) claims that: "Throughout the world, the power of fundamentalist religious leaders constitutes one of the most intractable cultural constraints" (Schoepf 1995: 34). She substantiates this statement arguing that fundamentalist religious leaders are discouraging communication about sex and fertility, which she sees central to prevention.

Similarly, in Zambia some argue against sexual education of young people, believing it will make them want to try it out. Sexuality, the effects of gender stereotypes, ideals on sexual behaviour and sexual negotiation is generally not spoken about, and public discussion is limited to the morality message (Dover 2001). Also in Kagera, Tanzania, sex is traditionally considered private, hence it should not be discussed openly with children present (Lugalla et al 1999). Furthermore, in the book *Rethinking Sexualities in Africa* Machera reveals that girls are not supposed to view their own genitalia and that it is insulting to refer to the vulva by its real name (Machera 2004).

Williams, Milligan, and Odemwingie (2001) explain that while objecting to the taboos surrounding sexuality, young people are denied access to family planning advice and services unless they are already married. In many developing countries there is a development towards physical and sexual maturity occurring at an earlier age than before, while the age of marriage is rising and taboos against premarital sex are breaking down.

[19] See also Piot 2004

More young people are sexually active at an early age without being married and this usually occurs without any use of contraception, increasing the risk of infection.

A 1996 study from Kenya revealed that religious people considered AIDS to be a disease affecting those who transgressed against God, thus they saw themselves as being at low risk of HIV. Religious leaders have also opposed sexual education arguing that it encourages promiscuity. The perception that AIDS is a disease for "high-risk" groups furthermore makes people less likely to take precautions (Akwara et al 2003).

Many men believe that in Africa women can not say yes to sex because they then will be labelled prostitutes, hence it is taken for granted that when a woman says "no" she actually means "yes". Moreover, for women it can be a better alternative to agree to sex, if not directly, than to be forced, since a real "no" is not an alternative. Nossum's interpretation here is that the problem may be that girls can not say "yes" rather than the fact that they can not say "no" (Nossum 2002).

5.3 "Good Sex" – Perceptions, Attitudes and Behaviour

In the Kagera region, Tanzania, in order to be considered as sex, sexual intercourse must involve penile-vaginal penetration with ejaculation inside the vagina. Many believe male sperm to be important nutrients for women, and that male sexual desire can only be satisfied with a release of sperm in a woman. Male sperm is also perceived to make the woman feel good. Contrary to the practice of "dry sex", which I will return to later, secretion of more fluid is highly admired among most Ba-Haya. The very common "Katerelo" sex style involves the rhythmic digital manipulation of the penis around the vulva for a prolonged time without penetration. The man's penis is used to excessively strike and brush the woman's genitals, and the rhythms of striking become so excessive that tender tissues can bruise and chafe, facilitating the transmission of HIV. Apparently, this sex style only works well without condoms (Lugalla et al 1999).

In Chiawa, potency and quality of semen are of strong symbolic value, and both are elements of male identity. Men are expected to be productive, women the recipients. Oral sex is seen as a perversion and masturbation a waste of semen. Condom use is also compared to masturbation, and informants argued that "It's like fucking yourself" and

"…you have to use your imagination, it's not real…" (Bond and Dover 1997: 381). During sexual acts, men are supposed to ejaculate more than once, and more than two rounds "shows love; that a woman is good and a man is strong" (Bond and Dover 1997: 381). Sexual satisfaction is here more related to achieved ejaculations than prolonged bouts of lovemaking. Men say that condoms reduce sensitivity,[20] and both men and women complain about the fact that it takes longer and that the number of rounds is reduced. Furthermore, It was pointed out as embarrassing to take condoms on and off for each round. Some women claimed they would rather catch HIV than use condoms, since successful sex implies both discharging sperm into the vagina and achieving conception. Disposal is also a difficulty, and condoms are disposed in latrines and in the bush where a lot of illicit sex takes place at night time. There were also a few stories of children using discarded condoms as balloons, and in the intense heat of the Zambezi river valley, storage is a problem (Bond and Dover 1997).

Akeroyd mentions that by some African cultures regular intercourse, without a condom, is believed to be necessary for the bodily health of both men and women as well as often also for a foetus, as condoms prevent the healthy flow of sperm. Other problems relating to condoms touched upon by Akeroyd are the fact that they are perceived to be unreliable, and that to suggest using one equals a confession of unfaithfulness or signals too much knowledge about sex (Akeroyd 1996, 2004).

5.4 The Lack of Condom Use

There are many reasons why people in South East Africa fail to use condoms. Lack of, or little access to condoms is one major explanation.[21] However, just as important are the many local cultural traditions and values rejecting condoms, the fact that sex is a taboo subject which leads many to neglect the "facts" of transmission out of ignorance, and the more general feeling among many of having no control over their own destiny or their present situation, making them see no reason to protect themselves against *one* of the many diseases and defeats killing people around them every day. This is a fatalism alien to

[20] See also Akeroyd 1996
[21] See among others Akeroyd 1996; Rweyemamu 1999; Valy 2004

western thinking, distant from the despair of many African societies, and I will address it more thoroughly later.[22]

To legitimize not using condoms, Schoepf's informants present what she calls "imaginary dangers", exemplified by women being warned of the potential of infection and permanent sterility and death if the condom should break or slip off, and remain in the vagina. Another important aspect of the lacking determination to use condoms is that traditionally women would rather risk pregnancy and illegal abortions than seeming prepared for sex by carrying condoms, due to the fear of being perceived as prostitutes (Schoepf 1995). Also Mulama (2003) reports that suggesting the use of a condom is a sign of being promiscuous.

Bond and Dover's work on Chiawa, Zambia, show that sex is seen basically as a procreative act, which in itself makes implementation of condoms difficult. One is not really adult before having produced children, and large families are still the ideal. Good, proper sex in Chiawa is vaginal penetrative sex without condoms, and procreation is an important part of "good sex". Many of the respondents in this research did not use condoms even when wishing to avoid pregnancy, as well as STDs and HIV, as there are general negative attitudes to condoms being connected to promiscuous people, prostitutes and disease.[23] A woman may be insulted by a man wanting to use a condom, or see it as a sign of him already being diseased. Herbs and "safe days" are preferred to prevent pregnancies and a belief exists that prolonged use of condoms leads to impotence, along with semen being perceived too valuable to be thrown away. A need for women to feel the ejaculation also makes them more unwilling than men to use condoms. Especially older women resist the use of condoms, and they are the one's teaching younger women about sex and marriage. Many are afraid of condoms getting stuck inside women,[24] and men refer to condoms as breaking, not strong enough and too small; statements which are likely to be related to male pride in sexual vigour. Furthermore, a woman initiating a new style in marital sex faces accusations of infidelity, as she must have had experience with another man to have acquired such knowledge. In Chiawa it is largely men who control condom use in sexual encounters, while women normally do not have any saying, and

[22] See Section 5.8 Fatalism
[23] See also Valy 2004
[24] See also Akeroyd 1996

only around 4 % of women respondents in Bond and Dover's study (1997) reported to have ever used a condom. 60 % knew where to get condoms (Bond and Dover 1997: 387), but women and girls are often too ashamed or too shy to request them. In this area, condoms used to be available for free, and consequently many refuse to buy any, even when they are cheap. Unavailability is however the most common reason for not using condoms. It was also pointed out that drunk people were more likely to have casual sex, but less likely to use condoms. This is not only a Zambian, or African, phenomena, but because of the high HIV prevalence in this region, one is especially liable to face fatal consequences here (Bond and Dover 1997).

Also among the youth interviewed by Heguye in Kahe, Tanzania, condom use was infrequent, but the youth had a rather high level of awareness and knowledge about condoms. The supply was inadequate, and negative perceptions of condoms existed. Condoms were believed to greatly reduce sexual pleasure, a pleasure one is entitled to as married people, which is why a wife could not ask her husband to wear a condom during marital sex. Furthermore, it is considered inconvenient to put condoms on, as well as take them off again, especially for drunk people, and condoms were associated with unfaithfulness and prostitution, [25] while also being perceived too expensive to purchase. For a period of time the MUTAN project,[26] a Tanzania-Norwegian HIV/AIDS project, supplied condoms free of charge, but when the study group left the supply ceased, as the local shops had given up providing condoms due to no sale at all. The majority of the young people reported to have unprotected sex, arguing that they could not stop having sex because of the lack of condoms (Heguye 1995).

From respondents in Tanzania and Kenya, Rugalema (2004) presents the perceptions and attitudes that condoms reduce pleasure, condoms often break, condoms are infected with HIV[27] and condoms promote promiscuity and extramarital sex, while Ndubani (1998) report from Zambia a perception of condoms affecting male potency.

Writing on sexual behaviour in Tanzania, Rweyemamu (1999) says it appears common to have more than one sexual partner, and condoms are not used once one are acquainted

[25] See also Akeroyd 1996
[26] Mradi wa UKIMWI Tanzania na Norway
[27] See also Valy 2004

with each other, with people probably not considering that one's sexual partners are just as likely as oneself to have additional partners with whom they do not use condoms either.

Talle (1995) reports a lack in knowledge about condom use also among the Maasai of Northern Tanzania. Many young Maasai men had heard about condoms, but never seen one, and they neither knew how to use one, nor where to get one. Condoms were associated with non-Maasai lifestyle, and to use them with Maasai women was voiced as almost impossible, as the women would refuse. To use one with a Swahili- or non-Maasai woman was however plausible to many.

In her research site in Mbale, Uganda, Nossum (2002) found the perceptions that sex is not pleasurable with a condom, condoms break, they can hurt the girl, condoms in steady relationships are a sign of mistrust and some find condoms unavailable or very expensive. Nossum also presents condoms as problematic because they do not only protect against sexually transmitted diseases but also against pregnancies.[28]

Among the Basoga of South Eastern Uganda, condoms are perceived to restrain one's pleasure. They are compared to eating sweets with the wrapping paper on, and are believed to damage the skin of the genitalia. It is also argued that since some can have sex with an HIV-positive person without getting infected, and condoms are not 100 % safe, why should one bother to use any? What's more, the children you "throw away" to protect yourself by using condoms are believed to curse you, a belief that prevents people from using condoms by fright. Suggesting or demanding the use of a condom is also here perceived as a lack of trust or love (Kyakuwa 2002).[29] The contraceptive effect of condoms is another reason not to use them in strongly pronatalist societies, and there is also a problem of disposal, as to where one should throw away used condoms. These concerns are accompanied by fears and rumours about health effects and reduction of sexual pleasure from using condoms (Akwara et al 2003). Writing on Kenya, also Akwara et al (2003) report a low rate of condom use in risky sexual encounters, with condoms being negatively associated with casual or illicit sexual intercourse and therefore not used by people perceiving themselves not to take part in those categories of sex.

[28] See also Section 5.4.1 The Importance of Offspring
[29] See also Valy 2004

Many participants in Nakuru focus-group discussions suggested condom use as a protective measure, but saw problems in carrying it out, and a blood test was suggested as the appropriate action to take. Half of the women's groups would not take any action, out of respect of their husband and to avoid a fight, as the women have little or no autonomy in making important decisions, including sex and their own health. One woman pointed out that women can only get protection secretly as the doctor would advise (Bauni and Jarabi 2000). Akeroyd in addition reveals that at some health clinics a woman needs her husband's permission for obtaining birth control (Akeroyd 1996). Refusing sex is not an option, and women taking initiative to protect themselves are likely to threaten their own economic and social survival by provoking their husbands and hence endangering their position as wives. Some men and women talk about health concerns and family planning, but family planning is believed to lead to loose morals, and runs in the way of the desires to have a son and to achieve a family the size of one's parents'. Means suggested for changing the behaviour of suspected spouses were giving love, including sexual satisfaction, reducing or stopping long trips, counselling and prayer (Bauni and Jarabi 2000).

In Kagera, Tanzania, on a question of how to avoid HIV, many responded to obey God, stopping adultery, abstain and to be faithful. Most conservative religious groupings oppose the use of condoms. Condoms are believed to cause female sterility, to pollute the womb, and to potentially cause injury or death if they slip off and get trapped in the vagina. Some also think that condoms are too thin to protect against anything. Men in Kagera complained about condoms lessening sensitivity, and condoms are also here believed to promote promiscuity and unfaithfulness, and they are seen as a sign of loose behaviour, something which is perceived very shameful. It is even shameful to buy condoms, and condoms are in general associated with mistrust (Lugalla et al 1999).[30]

In Silberschmidt's field work from rural Kenya and urban Tanzania (2004), condoms were reported increasingly common, but new partners stop using them once they know each other.[31] It is very difficult, or often impossible, for women to negotiate safe sex, and to suggest the use of a condom is seen as disclosing ones disrespect too openly. When

[30] See also Akeroyd 1996
[31] See also Rweyemamu 1999

extramarital relations are permanent, using a condom is not an issue for either women or men. People do generally not perceive themselves to be at particular risk; therefore they see little reason for taking protective measures themselves. Apparently, condoms hurt a man's ego, and semen is necessary not only for the conception, but also "to grow the pregnancy". Semen is perceived too valuable to be thrown away, and masculinity is closely associated also with fertility. Silberschmidt argues that men tend to refuse condoms because it is expected of them, and not necessarily because they personally resist using them. Furthermore, the rumour that condoms are infected with HIV is widespread (Silberschmidt 2003; 2004).

In their thematic pamphlet on HIV/AIDS in Zimbabwe, Kvam and Eskildsen (2002) point at the cost of condoms, stating that even if condoms are available they are often so expensive that most poor people choose rather to spend the small amount of money they have on food. Another important element in the deficient usage of condoms is the strong position of the Catholic Church in Zimbabwe, seeing that they do not approve of condoms. In stead they want people to abstain from pre-marital sex, and when married keep to one partner only (Kvam and Eskildsen 2002). Correspondingly, Setel (1995) refers to a Lutheran priest who implied that promoting condoms would equal promoting experimenting.

Religious groups in Chiawa oppose condoms, and the fact that condoms curtail fertility and save lives is used against them. The argument goes that condoms symbolises immorality and women's uncontrolled sexuality. Fertility is highly valued and STDs are shameful, causing a negative view on condoms as they prevent conception and represent disease symbolising infidelity, as well as unsuccessful sex and efforts to control reproduction. Christian religious groups also claim that HIV passes through condoms. Moreover, condoms enable people to engage in extramarital sex and cause mistrust in relationships, being a symbol of unfaithfulness. However, condoms are also by some associated with caring for oneself and one's family. If people use condoms at all, they tend to use them only within certain extramarital sexual relationships. The use is highly inconsistent, which seriously undermines their effectiveness for preventing HIV/STDs. Condoms are less likely to be used with "steady" or "decent" girlfriends or boyfriends, "steady" meaning not being seen with too many other men or women, without stating how

many is too many. In contrast to many other places and communities, in Chiawa there is a pronounced preference for married girlfriends and boyfriends as they are perceived likely to have a lower number of sex partners, hence being less likely than the unmarried to have STDs (Bond and Dover 1997).

In their article on family planning and sexual behaviour in Nakuru district, Kenya, Bauni and Jarabi (2000) say that even though the prevalence of contraceptive use in Kenya has been increasing, most people still object to the use of condoms. While people in the Nakuru district consider the risks of unwanted pregnancies and HIV to be serious problems, they do not use condoms within marriage nor refuse their partners sex, even when suspecting them of being infected and having concrete and legitimate fears of HIV transmission. Due to economic and social inequalities and age disparity, women in the Nakuru district are in a subordinate position, lacking decision making power. STDs are perceived as something one can contract from people from outside the area, and rural people see both STDs and HIV to be mainly urban phenomena, even though STDs are a serious problem in the area. Knowledge about condoms appears to be widespread, but their acceptability and use are not. However, many men resist condom use within marriage while being more willing to use them with extramarital partners. The women did not pronounce any explicit opposition against condom use, and many wanted their men to use them, while one woman concluded that people in rural areas lack knowledge of how to use condoms. Reservations against condom use mentioned were condoms rupturing in the process of sexual intercourse, reduction of sexual pleasure for both man and woman, that the condom is slippery, that men think condoms encourage immorality in their wives and that they themselves do not fulfil their duty as men in terms of sexual satisfaction if using condoms. Furthermore, religious teaching inhibits condom use,[32] disposal is a problem, people known to be using condoms are considered promiscuous and condoms are perceived to be something shameful. Interestingly, though, without being stated directly, it appears that men here are expected to satisfy their women sexually (Bauni and Jarabi 2000).

[32] This is not to argue that all religious leaders are against condom use. Non of my sources bring it up, but in this region there are also examples of religious leaders and institutions who take active part in sexual education and promotion of condoms in the fight against HIV/AIDS even though most preach abstinence and faithfulness before condom use.

Condoms are also viewed as Western-imposed. In Tanzania there is a widespread suspicion that the national AIDS control effort is subsidized by condom companies in Europe and America. Setel (1995) explains how rather than introducing regular condom use, people in Northern Kilimanjaro, Tanzania, reduce their number of partners. Some do however use condoms with partners they perceive to be especially risky, and young women generally consent to sex only with partners they consider "clean", while some insist on using condoms with all but one or two regular "permanent" partners.

The dominant ideology in Uganda, according to Obbo (1995), stresses morality, chastity and monogamy as more effective than condoms in the fight against HIV. According to "the dominant male and elite voices" (Obbo 1995: 80) information and knowledge would be enough to change behaviour, and hence they are supporting campaigns of abstinence and faithfulness. Social relations surrounding many sexual encounters are thereby ignored, especially the issue that many women are in no position to say "no". Obbo also points out that this moral encouragement takes place in "a condomless context". First condoms were not available and then they were portrayed as promoting promiscuity. Men also associate using condoms with eating sweets with the wrapping paper on, or with taking a shower wearing a raincoat, an association made throughout Eastern and Central Africa. Muslim men have besides been reported snipping tips off condoms before using them in symbolic association with their circumcised bodies. Used condoms are also perceived a problem, as they are discarded outside disco halls, and there is a concern of goats choking on them and children playing with them as balloons. Fear was also expressed of condoms falling off and getting lodged in the vagina, an image which naturally frightened women in terms of their reproductive health in a society where "barren women are pitied and mothers are respected" (Obbo 1995: 83).

Contrary to most of the literature reviewed here, Aliro, Ochieng and Fiedler's work on male adolescence and sex education in Uganda reveal that in a group of girls 15-19 years old, none reported having problem persuading boyfriends to use condoms as long as the request was made at the beginning of the relationship. This is however Uganda, the only East African country which has been successful in halting the spread of HIV, and it is unfortunately not representative of South East Africa as a whole. In Uganda urban boys also tend to have more positive attitudes towards women than their rural counterparts, and

condoms are an integral part of many Ugandans' sexual lives (Aliro, Ochieng and Fiedler 1999).

5.4.1 The Importance of Offspring

Baylies and Bujra (1995) state that in Africa fertility is very important to women's status, and therefore women's knowledge and attitudes relating to condom use are not enough to change behaviour. For many African women choosing childlessness is not an option, and to have children one must have unprotected sex.

Throughout South East Africa offspring is very important,[33] and therefore prevention of conception in marriage is often unheard of, making HIV prevention by promotion of condoms difficult. When a woman's value depends on her ability to reproduce, unprotected sex is necessary also when the husband has become HIV infected elsewhere. In Uganda, women are normally the ones blamed for infertility, furthermore the desire to have children, or children of a preferred sex, may trigger extramarital sexual relations (Sengendo and Sekatawa 1999).

According to Karanja's work from Uganda many men resist using condoms. It was argued that condoms do not work, and also here the metaphor that having sex using a condom would be like eating sweets with the wrapping paper on, was used. For some reason, HIV-positive men were especially reluctant to condom use, and one woman quoted her husband saying there was no reason for him to die alone. In order to have children women are forced to have unprotected sex whether or not one or both partners are HIV-infected, and some women secretly used undetectable contraceptives for child spacing, but without being able to protect themselves against sexually transmitted diseases including HIV (Karanja 2003).

In Kagera, the aim of sexual intercourse is procreation rather than recreation, and people marry in order to have children. Having many wives and fathering many children are signs of manhood, success and virility, and also here condoms face negative attitudes because they prevent conception (Lugalla et al 1999).

[33] Akeroyd 1996, 2004; Blystad 1995; Dover 2001; Sengendo [s.a].; Sengendo and Sekatawa 1999; Traditional culture 2004

5.4.2 Intravaginal Practices and Dry Sex

Based on their Zimbabwean study, Wijgert et al (2001) explain that women believe engaging in intravaginal practices[34] promote cleanliness, fertility and good health in addition to enhancing male sexual arousal. Conception is believed to depend on a clean environment and excessive vaginal secretion and semen are classified as dirt. Insertion of substances, often powder, inside the vagina to narrow it in preparation for sex is widespread. Resembling the cultural beliefs concerning good sex, this is a cultural belief of good conception. Other reasons for this practice are to dry the vagina to please the sexual partner, to warm the vagina, to increase the woman's own sex drive and to persuade the partner to be faithful. Sometimes these substances are left in the vagina during intercourse, but most often they are washed or wiped out before sex. The decision to use intravaginal practices is usually made by the woman herself and is not discussed with the partner, although dry sex is preferred by Zimbabwean men.

The phenomenon of dry sex is repeatedly mentioned as a risk factor in the literature reviewed.[35] Referring to Schoof's "Death and the second sex" from 1999, Umerah-Udezulu gives the following description of Southern African women's practice:

> These women dry out their vaginal walls with detergent, salt, cotton or shredded newspaper to create a dry environment for sexual intercourse. The dryness causes vaginal lacerations during intercourse and suppresses the uterus's natural bacteria, which then leads to higher rates of infection and contributes to the spread of HIV/AIDS. Even when condoms are used, women still risk becoming infected because condoms may slip or tear due to excessive friction in the dry vaginal environment. (Umerah-Udezulu 2001: 6)

Akeroyd (1996) adds that the use of intravaginal substances, vaginal drying and tightening, can cause both penis and vagina to become traumatized during intercourse and cause lesions.

According to Wijgert et al (2001), many researchers have expressed concern about the problems of reduced acceptability and efficacy of condoms where intravaginal practices are widespread. Condoms are used less frequently and when used they are more likely to break due to the increased friction, while many women do not want to use condoms

[34] See also Akeroyd 2004
[35] See among others Umerah-Udezulu 2001; Williams et al 2001

because “skin to skin contact is necessary for the magic of drying agents to work” (Wijgert et al 2001: 142). Whereas most women in their study indicated a liking of dry sex, many also regularly experienced pain during sex.

Dry sex is common also in Chiawa, Zambia, and women here believe it is shameful to be “watery”, as wet sex implies infidelity and a wish to prevent conception. Men and women agree that women should be dry and warm, “not like a snail” (Bond and Dover 1997: 383). Dry sex makes men feel big and women feel small and the lubrication provided by condoms is the opposite of this ideal. Some women also state that condoms cause pain. The use of agents to dry out the vagina may give women the perception of controlling intercourse and fidelity, and their need to satisfy men justifies the practice (Bond and Dover 1997).

5.5 Women’s Subordinate Position

The UNAIDS report “Facing the future together” (2004) focuses on gender inequality and the need to transform the status of Southern African women. It points at the inability of many women and girls to engage in sex as equal, or even willing, partners as well as the pressure on women to care, leading them further into poverty and making them more likely to engage in high-risk sex. Young girls are especially at risk due to physiological factors, as their vaginal membranes are still immature and easily torn during sexual intercourse, along with the fact that girls tend to have sex with boys and men at least 5 years their senior. This age difference creates unequal power relations which are often reinforced through coercion, abuse and violence. The older the man is the higher is also the likeliness of him having contracted HIV. Still, in Sub Saharan Africa, girls aged 15-25 are two and a half times more likely to be HIV positive than their male counterparts, and in Zambia and Zimbabwe almost 80 % of those aged 15-24 with HIV/AIDS are female (UNAIDS 2004b: 8).

Lugalla et al (1999) moreover bring forward girls’ early age of first sexual intercourse as an issue of concern. Before menstruation begins, the lower reproductive tract is immature and especially vulnerable to tearing, whereas to men, breaking virginity is a sign of power and control of female sexuality. Sometimes penetration is even done without foreplay while the vagina is still dry. A male informant summed up the gender inequality well,

stating: “Even if they suffer, it does not matter to me. Women are born to suffer” (Lugalla et al 1999: 395).

The IRINnews article *Traditional Culture Spreading HIV/AIDS* from 2004 on East Africa argues that the legal systems,[36] governance structures, value systems and wife exchanging with land or cattle all uphold the subservience of girls and women. Furthermore, widow inheritance, widow “cleansing”, wife sharing, polygamy as well as female and male circumcision, both due to reuse of unsterilised knives or razor blades and increased risk of female bleeding during sex, all contribute to the spread of HIV. Whereas boys are taught that being able to control relationships is a sign of manhood, while they are encouraged to be promiscuous, girls learn that males are superior in all spheres of life and are to be the masters of sexual relationships.[37] In addition, dowry payments make women men’s property, lack of basic education among girls and women make them unable to access HIV information[38] and young women are kept ignorant of sex as a sign of innocence, which is also making them unable to negotiate safe sex (Traditional culture 2004). This is also in line with Machera’s description of “coercive gender relations existing in most of Africa that predispose most women to infection” (Machera 2004: 167).

Akeroyd argues that especially young women may be powerless to control the sexual behaviours of their partners, as they are not in a position to resist sex. She also sees women’s vulnerability as in part a result of their legal status. Women are disadvantaged in respect to custom and they are deprived of some citizenship rights which make them subordinate to their husbands and their husband’s family in everyday gender relations. These are gender inequalities which are taken for granted by women as well as men (Akeroyd 2004).

Writing on Tanzania and Zambia, Baylies and Bujra’s (2000) starting point is that low levels of literacy among women in Africa make them especially vulnerable to HIV/AIDS. Women’s access to information about STDs and HIV, as well as health care, is limited because they are less mobile and also economically dependant.[39] Baylies and Bujra argue further that generally women are subordinate in sexual encounters and have very little, if

[36] See also Akeroyd 2004; Williams et al 2001
[37] See also Mulama 2003
[38] See also Mulama 2003
[39] See also Mbizvo 2000

any, influence on these. Subordination of women's needs and desires in intimate relations is linked to a general subordination in wider society: Women have less access to education, they are in a weaker position at the labour market as well as politically, and with little education and few saleable skills the subordination is most profound in women's economic position. The promotion of the ABC of HIV-prevention – Abstain, Be faithful and use Condoms – is based on a behaviour model of free choice, but in these societies there are often no real choices, especially not for women. Hence, this campaign rings false for most Africans and it has not been as effective as intended.

Based on research from Tanzania, Rweyemamu points out that women experience domination and discrimination their whole lives, as they are fed less than boys, they are less played with, they lack control of their own bodies, and many live in fear of violence.[40] This hegemony is deeply rooted and some men claim that for a woman to be dominated by a man is one of God's plans; women were created to service and be submissive to men, leaving no option for girls to say no to sex or negotiate safer sex. Others do, however, disagree with these cultural beliefs and claim that today a girl and a boy are on par and that a girl can complain if she is not pleased sexually by her husband. This author also believes that gradually Tanzanian men, particularly the educated ones, are starting to accept women's sexual needs. A Dar es Salaam butcher even claimed that a husband is never offended if his wife initiates sex, which is an example of women in cities having greater sexual freedom, while lack of education tend to make village husbands conservative (Rweyemamu 1999).

According to Lugalla et al (1999), the Ba-Haya of the Kagera region, Tanzania, consider women to be a weaker sex. This perception is put forward in the distinction that women are "married"; they do not "marry". Men are the ones who "marry" –the active tense of the word. The same verbal difference applies to sex; men act upon somebody sexually while women are acted upon. This is referred to as typical in most cultures in Sub Saharan Africa. Men take the lead and women's preferences are not discussed. Women are in fact not allowed to negotiate sex, and men decide when, where, how and with whom sexual relations are to take place. Most women are in no position to discuss condom use or refuse risky sex. Patriarchal authority is strong, with male dominance in both family and

[40] See also Kondowe and Mulera 1999

community, and polygamy is strongly supported. Trying to negotiate safer sex with their husbands may result in being thrown out of the marriage and losing access to work and farmland as well as children. A certain level of violence by husbands tends to be allowed by Ba-Haya traditions. Women's role is to obey and implement, and women are by men put on par with children. Men can easily throw their wives out and take new ones in their place. If a woman shows signs of HIV before her husband does, she risks being kicked out of the household and sent back to her parents. Some women thus refrain from voluntary HIV testing out of fear of testing positive. Women's experiences in marriage are summed up as oppression, subordination, powerlessness, poverty and exploitation.

Akwara, Madise and Hinde describe how Kenyan married women, trying to negotiate safer sex, face a danger of being suspected of promiscuity by their husband, even when the reason for bringing up the issue is knowledge about the husband's extramarital relations. In their study higher proportions of men than women reported risky sexual behaviour, but men's sexual behaviour also affect their women. While men have multiple sexual partners, women tend to have only one casual partner, and some are engaged in such sexual relations for economic reasons (Akwara et al 2003). Furthermore, Dover point out that in pre- and extra-marital relationships women are especially disadvantaged in negotiating (safe) sex because they have no ability to enforce men to take responsibility if they get pregnant (Dover 2001).

Writing about Africa in general, also Baylies and Bujra (1995) point out the striking gender inequality. While men may divorce wives who test HIV positive, most women are in no position to even negotiate safer sex. The two co-authors state that "Social structure limits the ability of women to become independent actors exercising social agency" (Baylies and Bujra 1995: 213). Women in Rugalema's work see AIDS as a disease they have no power either to control, or to run away from, as they were unable to control men, and for a woman to even talk about condoms was unheard of (Rugalema 2004).

Akwara et al (2003) see women's powerlessness to negotiate safer sex as "the central obstacle" (Akwara et al 2003: 386) to HIV prevention in Africa, while Akeroyd (2004) argues that what is important to notice is that emphasizing the situation of the weaker part in sexual interactions does not solve the problems of HIV transmission. When women are not in a position to protect themselves, it is not sufficient to teach *them* about the risks.

Karanja (2003) points out male infidelity to be a principal cause of HIV infection in women; married women are actually more at risk of contracting HIV than single women, due to the power relations in marriage. In the report this view is substantiated by the statement: "The single woman does not have a contract" (Karanja 2003: 23), which is important in a society where the belief is that wives have no right to deny their husbands sex.

Referring to "the muted voices of women", Obbo (1995) states without a question that the accepted religious and social practices that allow men to enjoy multiple partnerships while strongly condemning women's expression of their sexuality, have been key factors in the spread of HIV. While men choose sex partners, women are expected to be "available". Some adult male informants felt that it is a man's right to have pleasurable sex no matter what may occur, furthermore men increasingly perceived marriage to young women, and sometimes girls, the solution to AIDS.

5.5.1 Economic Dependence and Lack of Rights

Williams, Milligan and Odemwingie (2001) state that: "In most African cultures, women's lack of economic opportunity leads them to dependence on men" (Williams et al 2001: 6), a situation which deprives women of the right to refuse sex or demand safer sex.[41] In her thesis from the Mbale district, Uganda, Nossum claims that many women contract HIV having sex with nobody but their husbands,[42] and being economically dependent[43] they can not leave the marriage. Women have a weak position in society, and cultural tradition often conquer modern laws when it comes to inheritance from man to woman. This often leaves women with nothing, even though legally claiming 15 %, and that is an injustice with pronounced consequences in a time with AIDS (Nossum 2002). Correspondingly, Loewenson and Whiteside (1997) argue that women have more vulnerable employment status and security, lower incomes, less access to formal security and less entitlement to, or ownership of, assets and savings.

[41] See also Mbizvo 2000
[42] See also Violence [s.a.]
[43] See also Leclerc 2001

A 2004 UNAIDS report states that in many southern African countries, women still lack property and inheritance rights. They are treated as legal minors and made dependent on men, putting them further at risk of sexual exploitation and violence.[44] The fear of stigma and violence from one's partner is for many women an impediment not to getting tested or seek treatment for HIV. The power relations also contribute to women being reluctant to confront the family bread winner on the sensitive issue of using condoms (UNAIDS 2004b). Baylies and Bujra (2000) moreover point out that AIDS-widows without inheritance rights have limited options, making the path to sex work and other risky behaviours short. Also Akeroyd (1996) acknowledges that women have a relative economic, personal and social vulnerability, and some turn to sexual survival strategies which are in fact, due to HIV/AIDS, becoming strategies of death.

Obbo (1995) talks about patrilineal descent, the reality of women having no economic rights without husbands, and women's task being to be mothers to men's children, which force HIV-positive women to opt for maternity as the only way to access social status and resources. Based on her pre 1995 studies in Tanzania, Haram (1995) says that traditionally women were economically dependent on marriage, lacking the right of ownership of land, and their sexuality was closely connected with fertility and reproduction. She then present it as a positive development that women can now exchange their sexuality for a job opportunity, money, education or school fees.

Haram states that single women, unmarried, separated, divorced and widowed alike, are socially and economically marginalized, and therefore they tend to have multiple partners. If a single mother marries, she has to leave the children behind (the text does not say where/ with whom), and consequently such an opportunity is refused. Apparently, it is more attractive to have a sexual relationship with a married man with enough money for extramarital relationships. Women keep boyfriends to attain a higher economic standard, which in the time of AIDS can lead to death, but many can not afford to abandon the relationships in order to reduce the risk. Sexual relationships are often investments in social security for women in female headed households. Single mothers' optimal sexual partner is the affluent or elite man who has access to scarce resources, but since he is also likely to have a wide sexual network, he is a very risky partner. While men are considered

[44] See also Akeroyd 1996

polygamous by nature, female extramarital sex equals adultery and is disrespectful. Haram refers to a Ugandan study stating that "the major risk factor for HIV among wives is the extramarital sexual activity of their husbands" (Haram 1995: 45). Furthermore, the fact that women can not control their husbands' sexual life is a part of them not being able to control their own (Haram 1995). However, there are considerable national and local differences in women's degree of dependence and independent roles, most emphatic between rural and urban communities.

5.6 Risky Traditions, Rituals and Ceremonies

In this section I will present a number of cultural traditions, rituals and ceremonies that are all facilitating the spread of HIV. Traditional practices of female circumcision, widow inheritance, "katerelo" – the practice of achieving arousal by drumming the clitoris with the penis, which is seen incompatible with condom use, "wet" and "dry" sex, which are both likely to cause skin abrasions, and abstinence from sex with pregnant women or new mothers are all repeatedly mentioned as potentially generating the spread of HIV in South East Africa.

According to a National AIDS control programme (NACP) study referred to in Kondowe and Mulera (1999), Malawians continue to uphold cultural values, beliefs and practices which entail the risk of HIV infection. Kondowe and Mulera make mention of a series of cultural aspects that may contribute to the spread of HIV. The list consists of *initiation ceremonies,* where boys and girls learn theory and practice of sex before, and in preparation for, marriage, *death rites*, where the widow is required to have sex as a cleansing ritual, *property grabbing*, in which a widow's property is taken by male relatives and she is left with nothing, making the road to selling sex short, *widow inheritance,*[45] *polygamy*,[46] *traditional medicine* and the belief in *witchcraft,* which may prevent scientific understanding of HIV/AIDS and the practice in cases where a woman does not get pregnant, a traditional healer have sex with her, or recommend her to have sex with others, as part of the healing process (Kondowe and Mulera 1999).

[45] See also Section 5.6.1 Widow Inheritance and Wife Scaring Practices
[46] See also Section 5.7.1 Polygamy and Multiple Sexual Partners

To illustrate the influence of culture on HIV/AIDS in Uganda, Sengendo [s.a.] gives a list of cultural features including *twin rituals,* which are associated with large consumptions of alcohol, dancing, and merry-making: an environment conducive to risky sex, *post-partum sex*, a ritual where the parents, whether married or not, must have sex before they can have a normal sex life with any other person and *sex in the event of sending away one's daughter to get married*, the parents being the biological ones, no matter their relation at the time.[47] Male healers specializing in treating infertility by having sex with their clients is also here mentioned as a likely source of HIV infection. Also Obbo (1995) writes about a male diviner treating a woman for infertility by sleeping with her. He points out that even with high HIV prevalence in the area, no one seemed concerned about the dangers of that practice.

Initiation ceremonies are by some seen as a healthy form of health promotion, minimizing premarital sexual experimentation, while others blame it for promoting early sex between boys and girls and between men and young girls, as well as early marriages and divorces. In some of these ceremonies, a man has the task of anonymously deflowering virgins (Lwanda 2004). Webb reports from Zambia a concern that because the average age of marriage is rising, the time period between girls' puberty initiation ceremonies, which teach about sexual behaviour, and marriage, is extending. Girls are eager to act out what they have learned, and here being sexually aware also appear more attractive to boys. Initiation is however now on the decline in Zambia (Webb 1997).

Kondowe and Mulera (1999) also make reference to initiation and the fact that in some cases the initiates are encouraged to have sex upon graduation. Other cultural factors potentially facilitating HIV-transmission, mentioned by Lwanda (2004), are unmarried female's postnatal abstinence being concluded by surrogate sex, the use of surrogate in male infertility, the belief that STDs can be prevented with charms and vaccines, men generally refusing the use of condoms, the use of vaginal tighteners and men having mistresses.

In some rural Tanzanian communities it is common for a wife to return to her parents while pregnant, leaving the husband searching for other sexual partners. Rweyemamu

[47] See also Sengendo and Sekatawa 1999

(1999) also makes mention of some cultures in which it is believed that after a child is borne, the mother has to abstain from sex till the child reaches a certain age, because of a fear that sex will seriously affect the child, which is even another reason for the husband to look for sex elsewhere. The text does however not explain this belief any further, nor does it state any time period of the prescribed abstinence.[48] Correspondingly, Blystad (1995) points out that while Tanzanian wives are abstaining sex due to pregnancy, birth, convalescence and nursing of infants, their husbands have sex with other women within the accepted partner categories.

According to Akwara, Madise and Hinde (2003), it has been suggested that African societies are more tolerant of men's infidelity because of the practice of postpartum sexual abstinence.[49] In Kenya this abstinence is as short as 2-4 months, and the region with lowest level of reported risky sexual behaviour also has the lowest median duration of postpartum sexual abstinence. In Baylies and Bujra (2000), long postpartum abstinence is mentioned as protecting women against HIV, but at the same time their husbands are likely to have extramarital sex during this period, increasing women's risk.

Among the Basoga of South Eastern Uganda, blood and mothers' milk have been the basis for the local culture of kinship. This is now threatened by the knowledge of HIV transmission through sex and breastfeeding, at the same time as these fluids' cultural importance act as hindrance for changing traditions and risky behaviour. Ones mother's family is referred to as "those who breastfed us" and the belief is that if your mother never breastfed you, you would not have grown. To betray ones siblings, with whom one shared the breast, is to betray oneself and the mother's love. Handing out infant formula as breast milk substitute to prevent mother-to-child transmission of HIV thus undermines the reproduction of intimacy, family and belonging, and also women's social value, as giving birth is not sufficient to qualify as a good mother, one is obliged to express one's motherliness by breastfeeding ones children (Kyakuwa 2002).

Writing on Kenya, Akwara, Madise, and Hinde (2003) in addition draw attention to the role of ethnicity. Ethnicity is here presented as analogous to other cultural identifications in the

[48] See also Akwara, Madise and Hinde 2003; Bond and Dover 1997; Foreman 1999; Klepp, Biswalo and Talle 1995; Luke 2003
[49] See also Bond and Dover 1997

way that it may influence sexual behaviour through cultural beliefs and practices. This is exemplified by the traditional practices of widow inheritance and the practice of widows having sexual intercourse with a male relative of the deceased as ritual cleansing. In his press article from Kenya and Uganda, Mulama (2003) correspondingly presents a widow cleanser whose work is to perform a sexual act with women whose husbands have passed away. Most likely he is also spreading HIV on his way.

5.6.1 Widow Inheritance and Wife Sharing Practices

Widow inheritance is repeatedly mentioned, whereas not very much is said about it.[50] In addition to widow inheritance where the deceased man's brother is given the widow, Lwanda (2004) also tells about widower given wife's younger sister.

In the Kagera region, Tanzania, widow inheritance is common. Men here marry or have sex with widows of AIDS victims if they seem to remain healthy (Lugalla et al 1999). Also among the Basoga of South Eastern Uganda, widow inheritance has been common, but are, due to AIDS, now hardly visible (Kyakuwa 2002). Among the Iteso of Kawempe, Uganda, widows belong to the heir. A widow is inherited by the heir regardless of the cause of death, and that man is entitled to all privileges and benefits of the deceased. Thus, if the deceased died of AIDS, the heir will most likely also inherit his HIV infection through the widow (Sengendo [s.a.]).

Among the Basoga of South Eastern Uganda, the practise of double succession is very important. Sex between a man and his brother's wife is traditionally accepted, and when a man marries a woman, she becomes a wife, and hence property, to the entire clan. Children born out of such relationships are legitimate children.[51] Basoga men may however refuse such sexual relationships, except if it is a death where a brother has to take over as the heir. The word "adultery" does not have any equivalent in Lusoga vocabulary,[52] but women are punished for sexual relationships outside their husbands' family or lineage (Kyakuwa 2002). In Kagera, if the husband is absent, other men within his family are also allowed to have children with his wife (Lugalla et al 1999).

[50] See among others Baylies and Bujra 2000; Kvam and Eskildsen 2002; Lugalla et al 1999; Rweyemamu 1999; Sengendo and Sekatawa 1999; Traditional culture 2004; UNESCO/ UNAIDS 1999
[51] See also Lugalla et al 1999
[52] The Basoga language

Sengendo also makes mention of a practice in Uganda where boys have sex with younger wives of their fathers, girls often their own age (Sengendo [s.a.]).[53] Sengendo and Sekatawa (1999) note that among the Bahima of Uganda, the father of the bridegroom used to have the first sexual access to the new bride "to test where his cows have gone" (Sengendo and Sekatawa 1999: 10), as the bride was an addition to the family and the clan. The report does however not reveal if this is still a current practice.

5.6.2 Genital Surgery

Akeroyd (1996) argues that too little attention has been paid to cultural modification of genitals in the pre-1996 HIV/AIDS literature from Africa. According to Umerah-Udezulu (2001) on the other hand, there is no direct statistical connection between genital surgery and the spread of HIV in Africa, but poor performed surgeries and genital bleeding during intercourse are potential sources of HIV transmission.

According to Akeroyd (1996), the results of the research on the connection between male circumcision and HIV-prevalence vary from circumcised men having a lower HIV prevalence to circumcised men having a higher HIV prevalence than those uncircumcised. She hence argues that the additional finding of male circumcision also benefiting women against HIV-transmission should not be given too much emphasis.

According to Nossum's thesis (2002) from Uganda, male circumcision is what gives a boy his identity as a man, along with it being an arena for HIV transmission. In her view, the following party with lots of alcohol and sexual activity is however more important as a potential source of transmission than the surgical procedure itself.

Correspondingly, Schoepf (1995) mentions Eastern Ugandan male circumcision ceremonies as an arena of HIV transmission as family return to their villages to honour the boys and engage in a celebration where alcohol and sex is a valued part of the exchange between visitors and hosts.

In his listing of risky cultural practices, Sengendo [s.a.] mentions female genital modification through labial elongation. He refers to it as a means of promoting mutual

[53] See also Sengendo and Sekatawa 1999

pleasure[54], but he does not explain why he perceives it to constitute an increasing risk of HIV infection.

5.7 Gendered Sexuality

In the following I will look into gender inequalities and gender roles relating to sexuality. The article *Traditional Culture Spreading HIV/AIDS* points out that much due to rape, coercion and sex with older men, as well as biological factors and man-made socio-political factors, girls aged 15-19 in Kenya, Uganda and Tanzania are six times more likely to be HIV-positive than their male counterparts (Traditional culture 2004: 1).

5.7.1 Polygamy and Multiple Sexual Partners

An explanation often proposed for the high levels of HIV infection in Africa is *polygamy*. It is argued that multiple partners increase the size of sexual networks, and hence increase the risk of HIV transmission. Polygamy is also perceived to promote extramarital sexual relations as young women married to old men seek younger partners for sexual satisfaction, while competition between co-wives about the sex and number of ones children may encourage them to search for alternative partners for conception outside the marriage (Ocholla-Ayayo 1997).[55]

Among the Barabaig in Tanzania, polygamy is the preferred marriage form. Both sexes have sexual relations with others than their spouses, and women may receive their husband's clansmen or friends as lovers and have their children. Both love and reproduction are motives for extramarital relations, and the women have considerable control and power of persuasion in relationships with men, although less so with their husbands than their lovers (Blystad 1995).

In Tanzania, tribal customs as well as Christian and Muslim religions dictate abstaining from sex before marriage and staying faithful within, while neither of the two is widely practiced. Both Muslim and many tribal customs do however allow a husband more than one wife. In some regions the husband is also free to seek a son with another woman if the

[54] See also Machera 2004
[55] See also Sengendo and Sekatawa 1999

couple is childless after five years of marriage or their only offspring are girls (Rweyemamu 1999). Among the Meru in the Arusha region, Tanzania, a strong Puritanism exists, but in real life there is much more tolerance for both premarital and extramarital sex, as long as it is done with dignity and respect, discretely and not for everybody to know (Haram 1995).

Sengendo and Sekatawa's report (1999) from Uganda present the general belief that men are inherent polygamous and that it is normal for men to have more than one wife. A man cannot be satisfied with only one wife, and the respondents in the study perceived absolute monogamy to be rare. The wives in polygamous marriages are however not always aware of each other, as they do no longer always live together. The overt polygamy has also been declining, but the number of sexual partners has not. Reasons for having multiple partners, given in earlier studies mentioned here, were lack of sexual satisfaction, unfaithfulness, conflicts between partners, alcoholism, impotence, infertility, lust for too much sex, partner's labour migration, seeking a child of another sex, potential material gain, peer influence and curiosity.

Kyakuwa (2002) points out that Uganda is traditionally polygamous, and both the formal, legal form and the more informal version are deeply rooted.[56] All marriages start with only one wife, and there are many reasons for moving on to polygamy. Reasons mentioned by Kyakuwa are infertility, desire for children of the other sex, demonstration of virility, and economic gain for the husband in the form of free labour. Kyakuwa argue that polygamy does not in itself increase the risk of HIV, as long as all parties are faithful and were "clean" from the start, but in addition to men tending to have multiple sexual partners, many wives feel neglected in polygamous marriages and unmarried men tend to have relationships with these. For the first wife, an additional wife does however also mean one more person to share the burdens and work with, and therefore also many women appreciate this type of arrangement. Nonetheless, among the Basoga, the social valuing of polygamy is on the decline, but men still appreciate multiple partners, which is putting them at increased risk of HIV. The degree of sexual relations between relatives, due to wife sharing practices, can represent a risk of HIV, but this limitation of potential sexual

[56] See also Sengendo and Sekatawa 1999

partners can also protect against transmission, as long as nobody gets infected from other sources and hence brings HIV into the sexual network (Kyakuwa 2002).

Sengendo [s.a.] also links polygamy to poverty. He argues that polygamous marriages may lead to too large families, resulting in a domestic deprivation where the family is incapable of acquiring the amount of resources necessary to educate and support all its members in social and economic well-being.

In accordance with Kyakuwa, also Nossum (2002) assert that the attitude towards polygamy is changing in Uganda, but only in marriage, not in relationships. Female lovers do, however, have fewer rights than if they were wives, and the lack of wedlock hence makes their situation less secure. Furthermore, in Nossum's work it also appears easy to get involved with a new partner, both for men and women, when one's steady partner is far away due to education or work.

Writing about Kenya, Akwara Madise and Hinde (2003) explain that while men are allowed to have multiple partners, women are not, leaving women out of control of elements of their own sexuality. Risk-taking behaviour in Sub Saharan Africa is associated with gender inequalities, and while women are generally subordinate, the belief is that men have stronger sexual drives than women, and that men can not do without sex.

Haram (1995) talks about the Meru people in the Arusha region, for whom social and economic circumstances are important for the choice of partner. It is commonly held that it is difficult to find a husband, due to a drastic decline in polygamy and an increasing number of boys leaving the area for education and work elsewhere. The result is a "deficit" which creates an atmosphere in which young women would enter into risky sexual situations to "hook" a potential husband. To optimize one's chances of marriage young women often maintain sexual relationships with many men simultaneously. Meru boys also engage in risky sex as they go to town to work in order to save up money for a house and bride wealth. The social sanctions are less strong in towns and there is an easier access to women. Many get involved in a wide sexual network, exposing them to the risk of HIV infection, which they may again pass on to their future wives.

Heguye (1995) reveals that in Kahe, Tanzania, the perception is that a normal and healthy person should not go long periods without sex, as lack of sex may lead to physical

disorders and insanity. Single young people of both sexes here consider it almost impossible to have only one sexual partner. Sexual relationships are not permanent and it is convenient to have more than one partner when a relationship ends, as it may take some time to find a replacement. Everybody practice penetrative sex, as the norm is.

Looking at Talle's study (1995) among the Maasai of Kenya and Tanzania, it becomes extremely clear how impossible it is to generalize over a region as vast as South East Africa. Due to certain social practices and cultural norms, the pastoral Maasai of Tanzania and Kenya are at particular risk of STDs including HIV. Men are organized into age-sets and then divided into corporate age-groups "arranged hierarchically within a framework of authoritative positions and rules of appropriate behaviour" (Talle 1995: 71). From about the age of 16-18 years, boys are separated from the rest of the group and close friendships develop between them during this time which is called moranhood. The Maasai morality system allows men of the same age-group to have sex with each other's wives, for Maasai girls to make their sexual début before maturity, and for polygamy to be widespread. While it is perceived obvious that men search mating partners (women) everywhere they go, women are expected not to show sexual desire by initiating or taking a lead in the act itself. Sex is here linked not only to fertility but also with pleasure and joy. Within marriage, inequality is built into the sexual relationship, while lovers are related to as equals.[57] Traditionally, marriage is arranged by others than the two getting married, and the marital sex is first and foremost to have children. To perform marital sex is thus an obligation. Sex before and outside marriage means pleasure and entertainment, and in such relationships, gifts of love are exchanged. Not having lovers is an unthinkable phenomenon among the Maasai, and being a virgin bride is awkward, bringing embarrassment to one's family. Sexual debut of Maasai girls is at the age of 10-12 years, and they have sex with the morans only, the age group undergoing moranhood. There is a high level of sexual activity with a multitude of partners, and there is a pronounced social pressure on young men to perform sexually. Love affairs are created, and these continue well into the girls' married lives. The morans they interfere with are however not potential marriage partners because of the difference in marriage age for men and women. Furthermore, the morans have meat-camps in the bush with sexual abstinence, which is

[57] See also Karanja 2003

believed to make them very potent and fertile, and their compiled semen is believed to help, being almost a prerequisite, for girls to reach maturity and develop breasts. Both women and men have several partners simultaneously, with two or three permanent lovers in addition to their spouses being common. Some do also have some additional short-term love relationships. Unmarried or divorced women may have 10 lovers simultaneously, with the most popular ones having 15-20 or more. The love relationships are regulated by strict principles of moral and social conduct, and a woman who does not attract any lovers is perceived abnormal.

In 1995, AIDS was a disease the Maasai had heard of, but not yet seen. They saw sex with prostitutes or women outside their own community as the major source of infection, but the idea of paying for sex was for them disgusting as it was wasting money on something circulating free in Maasai communities. Maasai women do not traditionally seek marriage or sex with men outside their own society, but this is changing as Maasai women make friends with “Swahili” males in urban centres where they sell milk and buy consumer goods, explained by economic needs. The concept of monogamy is alien, and sex with multiple partners is not of itself perceived risky. What is believed to be risky by the Maasai is sex in relationships transgressing moral norms (Talle 1995).

Nossum (2002) reveals that the average age of sexual debut in the Mbale district, Uganda, is 11-14 years, with girls ranging even younger. Sex is socially and culturally expected. Wives are expected to be faithful, husbands are not. A man sticking to one partner is looked down on by his peers for lack of sexual prowess, and therefore feels pressure to be sexually active. To express ones sexual prowess implies having several partners, and celibacy is socially deviant among men. To choose abstinence implies a reduction of masculine identity and is feared more than HIV; being “clean” means nothing if one is no longer a man. A cumulative prestige is associated with a man’s number of partners and/or children.

Kyakuwa (2002) points out that among the Basoga, a decrease in traditional sexual education means that people do not know how to please each other, contributing to increased infidelity. The new freedom of speech “given” by president Museveni, which now allows people to tell their partner about sexual needs, has not changed this. Kyakuwa does however not address to what degree this freedom is actually present in individual

homes. However, he declares that women do have a certain degree of power in sexual relationships and many are in a position to say no, as well as "demand" their own satisfaction, even though there is little focus on how to please women.

Furthermore, the fact that Basoga women can refuse sex and report their husbands for marital rape gives men a reason to seek additional extramarital partners to satisfy their sexual urge. There is a belief that some men and women are sexually unsatisfiable, needing several partners while looking for one who can truly satisfy them. Among peer at the bar, having lots of experience is prestigious, and it is moreover claimed that experience is the best teacher. In addition, economic benefits are also here a motive for extramarital relations (Kyakuwa 2002).

Ocholla-Ayayo's study (1997) from Kenya shows that also here extramarital sex for many is an economic necessity as a source of income.[58] For others, the fact that many men migrate to towns in search of employment contribute to both husbands and wives starting additional sexual relationships outside the union. Extramarital affairs are common and some respondents believed that access to contraceptives increases sexual activity. Traditional norms restricting pre- and extramarital sex are no longer applicable in Kenya, and the participants in Ocholla-Ayayo's study appeared to be more concerned about the physical consequences of these sexual relations (STDs/ HIV and pregnancies) than about the morality.

In his article on Tanzania, Rweyemamu (1999) claims that the more educated a woman is, the more likely she also is of having only one sexual partner, while educated men are more likely to have several partners. Many believe that sexual abstinence is harmful for both men and women, and young men believe in a physical need to have regular sex. This also legitimises sex before marriage, and adolescents are ridiculed by their peers if they have no boyfriends or girlfriends. The issue of non-sexual relationships is somewhat missing here, as it appears assumed that having a boyfriend means having sex. Furthermore, for men it is important to produce children to inherit them, which is also a rationale for extramarital sex.

[58] See also Section 5.7.2 Transactional Sex and Age Differences

Also among the Tonga people of Zimbabwe, premarital sex is common, as is polygamy, extramarital affairs and rape. Moreover, 21 out of the 40 respondents in the 1999 UNESCO/ UNAIDS report on a cultural approach to HIV/AIDS prevention and care, agreed that women have no right to demand fidelity from their husbands, while 39 reported men to be the one's initiating sex in a relationship (UNESCO/ UNAIDS 1999). The report does however not say anything about the variation in answers given by men and women, which I think would be considerably more informative and interesting.

According to Ocholla-Ayayo (1997), in Kenya, adolescent sexuality and premarital sex is not condemned like before, and premarital pregnancies are no longer considered a disgrace because they are so common. A 1989 study from the Rift valley province revealed an average age of first intercourse of 11 years, thus many are even younger when starting sexual activity. Many Kenyans however prefer to think that all young people will abstain until marriage, even though not many did themselves. This is an attitude which is likely to restrain the HIV prevention, and adolescent sex often involves numerous partners, as teenagers generally change partners often. The respondents in Ocholla-Ayayo's work show little faith in school-based education campaigns, arguing that young people learn by experience. The impression given is that sexual education does not already take place in schools.

5.7.2 Transactional Sex and Age Differences

Some ancient traditions or cultural traits which facilitate the spread of HIV may also be reinforced by the presence of HIV. Sugar daddies[59] and the appurtenant age difference is not new,[60] but it appears that HIV has caused men to seek out younger and younger girls, believing them to be "clean" and "safe", not yet infected with HIV.[61] Having sex with a virgin is also by many believed to cure HIV/AIDS.[62] The younger the girls are, the more vulnerable they are to HIV transmission,[63] and as more men look for younger partners more and more of the young girls are already HIV infected.

[59] See among others Dover 2001; Haram 1995; Obbo 1995; Rweyemamu 1999
[60] See among others UNESCO/ UNAIDS 1999; Williams et al 2001
[61] See also Baylies and Bujra 2000; Lugalla et al 1999; Williams et al 2001
[62] See among others Kvam and Eskildsen 2002; Luke 2003; Umerah-Udezulu 2001
[63] See among others Akeroyd 2004

Webb (1997) states that the direct link between HIV and poverty is often referred to, but not so often explained. In his book on HIV and AIDS in Africa, he makes use of the term "transactional sex" to explanation. Some sort of exchange in return for sexual favours is common in regular relationships as well as in more casual liaisons. [64] In Africa, sex is commodified and according to Dervla Murphy, who travelled through Tanzania, it is quite common for girls to sell sex without feeling ashamed of it, and rich men like to show their money by purchasing a variety of girls as commodities. Women are economically dependent on men and the phenomenon is also an embodiment of economic power manipulation. Webb claims that the concept of sugar-daddies, and in some instances also sugar-mummies, is common across all of southern Africa. He moreover argues that the sugar-daddy phenomenon has grown because of the widespread belief that young girls are free from HIV infection, which in turn to some extent explains the low rate of condom use in these relationships.

Among the Meru people in Arusha, most sexual networking has a transactional aspect, and according to Haram "some kind of gift-giving is central to the understanding of both the gender-specific differences and the reason why teenage girls are the most vulnerable to the spread of HIV" (Haram 1995: 32). At the same time, if girls agree to sex too early, they are at risk of being labelled "loose" and the boy will move on, but agreeing to sex means more gifts, and for many young girls and women, sexual relationships are the only means of gaining items like soap, body lotion, shoes and nice dresses. The exchange of gifts is however very important in creation and maintenance of any social relationship, not only the sexual ones. Among the Meru it is perceived ideal to have several premarital relationships simultaneously for both boys and girls, but girls must be careful not to cross the line of being "loose" (Haram 1995).

Schoepf (1995) state that economic insecurity and dependence among women lead to risk behaviour as women use sex with multiple partners as a means of supporting themselves and their families.[65] Young girls are especially vulnerable, exchanging sex for food, clothes or grades in school. The fear of AIDS encourages older men to have sex with young girls, who they perceive unlikely to be infected. In 1995 HIV was spreading fastest

[64] See also Leclerc 2001
[65] See also Akeroyd 1996

among adolescent women and ten years later young African women still surpass their male counterparts in the statistics. Women without an income of their own are not in a position to negotiate safe sex or refuse unsafe sex, and what used to be a strategy for survival for poor women now leads to AIDS and death.

Sengendo and Sekatawa (1999) state that the phenomenon of sugar daddies is common also in Uganda and some chose to take on small children both because they do not yet have rent expenses, hence they are relatively cheap, and because they are perceived less likely to be HIV infected. Sengendo [s.a.] sees the sugar-daddy- phenomenon as sexual exploitation, where grown men give school-girls little favours in return for sex.

In Tanzania, girls aged no more than 10 or 11 have sex with men for chips, coke and money for transport or school. This practice does also put boys at risk, since their potential sexual partners and wives may already have got HIV infection from older men. Baylies and Bujra point at the need for young girls to sell sex for survival as it is cheaper for men to pay for casual sex than to get married, and a rising number of people stay unmarried. They argue further that it is not gender difference but gender inequality that puts both women and men at risk (Baylies and Bujra 2000).

In Kagera, Tanzania, sex is seen as a form of reciprocity and exchange, as men give material things in return for child bearing and sexual satisfaction. Both men and women commonly refer to women's sexual organs as her asset or capital, and sexual relations are considered women's work, not pleasure (Lugalla et al 1999).

Writing about young people in Kahe, Tanzania, Heguye (1995) claims that single women aged 18-25 have sexual partners for economic survival. Many informants had one or two children, and with several partners simultaneously they were materially more secure. It was also common for single mothers to sell local beer and supplying the customers with sexual services. Many of their customers were traders visiting during market day.

Haram (2004) reports from urban Tanzania that a growing number of women choose to stay unmarried while being involved in transactional sexual relationships. Adult, independent women keep relationships with men acting as sugar daddies and many enter into relationships with men to gain access to resources, including houses, land and jobs. "Polyandrous motherhood" is also described as common, with women giving birth to a

number of children with various fathers. This is explained by men wanting their lovers to have their children while the mothers must restrict the economic support they receive from each man not to be perceived financially incapable of providing for her child. The fear is that such an accusation can result in the mother being deprived of her child by her lover, and hence loose respectability, as motherhood is equated with respectability. Furthermore, having the attachment of husband and wife is by many perceived to limit the woman's freedom both in relation to her money and her movement, and accordingly one can see a steady increase in unmarried women and single mothers.

In her article on the age and economic asymmetries in sexual relationships, Nancy Luke (2003) points out that adolescent girls are at a disadvantage in negotiating sexual relations with older men. Women's sexuality is particularly pronounced in terms of economic value, and population growth has created a surplus of young girls in relation to older men who are at a shortage. Because of a reduction in traditional sex education, adolescents get most of their information from their peers, leaving many girls with little knowledge about their own bodies, reproductive system and sexual processes, while valuing sexual relations which gives them social status among their peers as well as economic benefits. Adolescent girls having older partners appears to be the norm in Sub Saharan Africa, but the majority of their partners are only a few years their senior. Luke concur that sugar-daddy relationships are common, but exchanging gifts or money for sex is common also in relationships where both parts are adolescents, as girls tend to expect some sort of payment for sex. None of the adolescents in the studies reviewed by Luke did however associate this practice with prostitution, something which is socially unacceptable in their eyes. This "missing link" might be explained by the fact that gifts are not given at every interaction (Luke 2003).

Many young girls choose much older partners looking for love and eventually a spouse, as they are more likely than younger males to be economically secure, more serious about marriage and perceived more likely to marry or support a girl if she gets pregnant unintentionally. Older partners also ensure girls of attracting boyfriends and of being sexually active, which is expected of them, in addition to providing money and gifts for luxuries. Others keep older partners for material benefits only, while having younger boyfriends with the intention of marriage. The literature Luke reviewed suggests that

girls' reasons for engaging in these relationships are more often desires for status and gifts than economic need and extreme poverty. Girls seem to have a high degree of control over partnership formation and duration, but the older men are in power within sexual relationships, including when it comes to decisions about safer sex and condom use (Luke 2003). Baylies and Bujra (2000) report that in some areas it is common to marry women the age of ones children, or even grandchildren.

In addition, Webb (1997) reports from Zimbabwe that young girls have been choosing younger boys, believing them to be HIV free. Targeting one age group believing it to be HIV free can however result in this group experiencing an increased spread. Furthermore, a study of adolescent sexuality in Uganda revealed a belief also among male students that young girls contracted HIV from adult partners, with whom they had sex for money, and then passed it on to their young boyfriends (Webb 1997).[66]

Akeroyd (1996, 2004) sees age difference between the spouses likely to encourage compliance and passivity in women, and she gives the example of Setswana culture in Botswana where the ideal gap is at least ten years.

5.7.3 Masculinity and Expectations to Perform Sexually

In addition to the phenomenon of men choosing younger and younger sexual partners, also notions of masculinity can be reinforced by the presence of HIV. In situations of economic decline, gross unemployment and increased focus on the empowering of women, their masculinity is by many men perceived the only asset they have left. Often men are made aware of the risk of HIV, but dismiss this risk if it challenges any part of their masculinity - a masculinity which often implies a high frequency of unprotected sex with more than one partner. Women are not the only ones without control of their situation; nor men are in control of the environment in which they live and act, taking part in what appears to be a self destruction of society. While men are more often than not responsible for physically spreading HIV, they are not alone to *blame* for the spread or the consequences of the HIV/AIDS pandemic.

[66] See also Baylies and Bujra 2000

According to Ndubani (1998), young boys in Zambia spend most of their time together with other boys and men as part of the socialization process. Men are to have a superior position, and the perception goes that one can not learn anything from a woman. In Zambia there is a general high level of pre-marital sexual activity, and boys are supposed to experiment or test whether they are "real men". The saying "a man can not eat the same food everyday" (Ndubani 1998: 55) is used to explain the desire for having more that one sexual partner. In addition, Bond and Dover (1997) present the belief that men have a need for release, and that they are not able to control their sexual appetites for long periods. Hence, if a man works away from home he is suspected of having a girlfriend.

In their article on Uganda, Aliro, Ochieng and Fiedler (1999) point out that across Uganda there are many differences, but also similarities. Men are expected to perform, to have frequent sexual intercourse, with one or multiple partners, and boys are encouraged by peers and fathers to get girlfriends to prove that they are real men and not impotent, while women are expected to remain faithful to their husbands and to please them sexually. Most Ugandan cultures mark the transition from child to adult, but the form and extent of sexual education varies widely, and there is a traditional belief that girls, but not boys, should be virgins on marriage. It is the opinion of most that boys should have sex before marriage to practice, and because it is difficult not to. Furthermore, in a group of young boys, everybody agreed that when a girl says "no" she actually means "yes", and if a wife refuses sex, the husband may have sex with another woman.

Sengendo [s.a.] also reports from Uganda that boys are encouraged and expected to have frequent sexual relations, while girls are expected to stay virgins until marriage and be faithful in marriage. In his study it is also indicated that love without sexual intercourse is considered to be "empty love" whereas people who chose to remain virgin "for long or beyond twenty" (Sengendo s.a: 16) are considered impotent or abnormal. Two pages later it is however stated somewhat to the contrary that virginity brings honour to the family and the individual, being associated with freedom from disease. But virginity is emphasized and gives cultural esteem for girls only. Kondowe and Mulera (1999), writing on Malawi, correspondingly present the perception that manhood without sex is incomplete.

According to Foreman (1999), men are more likely to have two or more concurrent or consecutive partners while women are more likely to be faithful to men from whom they contract HIV, and less likely to pass it on. In addition to the social and economic factors of poverty, illiteracy and traditional customs, men's refusal to condomise or to be monogamous denies women of the opportunity to protect themselves. Even when aware of the risk of both transmitting and getting infected with HIV, many men fail to protect themselves. Foreman argues further that while women are vulnerable to HIV because they have limited opportunity to protect themselves, men are at risk because they refuse to protect themselves. The combination of cultural perceptions of masculinity and lack of knowledge can thus be fatal.

In her article "Silence, AIDS and sexual culture in Africa", Leclerc points out that men are perceived to be biologically programmed to need sexual relations regularly with more than one woman, whilst the use of condoms is a sign of mistrust and promiscuity, and almost unheard of in marriage. Many partners avoid direct communication and assume that men are to be in control of sexual encounters, and men are believed to have a right, or even duty, to force themselves onto women who display reluctance or shyness (Leclerc 2001).

In his doctoral thesis on gender and HIV/AIDS in Zambia, Dover (2001) explains how the culture of gender is strongly related to the biological reproductive differences between men and women. For boys, positive masculine values are the negation of feminine attributes, and growing up they prepare for looking after females, including their mothers. Women's role is linked to domestic and mothering identities, while men's role is dependent on the modern economy as providers. Moreover, men's definition of masculinity in terms of potency, strength and hegemony is dependent on the counterweight in women. A real man should have others dependent on him while not needing support himself; he is the head of the household and the undisputed final decision-maker, an authority which is related to his ability to financially provide for his family. Economic decline does however make this problematic, as women's contribution from subsistence economy, informal sector, food for work, and formal employment is increasingly important for the family economy (Dover 2001).

In Dover's Zambia, having a mistress is proof of male wealth and potency, but a mistress also provides a more relaxed sexual relationship by avoiding the spouse role. Sexual

abstinence is perceived harmful to male potency and mental balance,[67] and men consider themselves as needing sexual variety, thus having the right to seek it. Female sexual desire is on the other hand downplayed, and women are characterized as tempting men to have sex because they are greedy for presents, or because of poverty. Male risk taking can be a consequence of the ideas of male strength, exemplified by one young man in Goba who believed himself to be too strong to be overcome by a woman's blood, as sex is referred to as mixing bloods, thus he did not see himself at risk of contracting HIV. The perception of men's sexuality as "natural" also takes away the responsibility which is normally a part of the male role, and the stereotypical roles actually prevent both genders from negotiating sex (Dover 2001). Baylies and Bujra (2002) also depict a belief among men that without sex they become abnormal, but intercourse is perceived crucial for the physical and mental wellbeing of both men and women.

Young Zambian girls would like for a husband to listen and discuss, but still be the head of the household. If the wife would take on male responsibilities, both man and wife would loose respectability. Western feminism put forward in aid projects to empower women thus feels like a threat to male and female roles with ideals of proper and respectable women and men. Zambia is however changing and women are entering politics and what used to be male professions, while tasks and responsibility at the household level is increasingly shared – a cooperation which is positive for the fight against HIV/AIDS. Both men and women in Zambia are positive about women's rights, but many are suspicious of the "gender"-focus, and men do not see themselves as benefiting from equal rights (Dover 2001).

Silberschmidt (2004), writing on Kenya and Tanzania, argues that socio-economic change in East Africa has increasingly disempowered men, and to strengthen their masculinity and self-esteem many men engage in multiple sexual relations and aggressive sexual behaviour.[68] As many men have become labour migrants, their women, being structurally subordinate, have taken charge at home, and male control over women has weakened as their position as breadwinners and providers is challenged. Men are often expected to have multiple partners and both men and women interviewed in Kenya and Tanzania reported

[67] See also Baylies and Bujra 2000
[68] See also Silberschmidt 2003

opinions that “a real man needs to demonstrate that he can handle more then one partner” (Silberschmidt 2004: 238). Three wives is here presented as the ideal, having one for getting children, one to work and one for pleasure. The belief is that men have a constant need for sex and since women do not, men “need to go outside to feel like a man” (Silberschmidt 2004: 239). Men can not resist women, so in need of control they turn aggressive as the concept of a “real” man still includes male (sexual) control over women. Most boys are taught that they are the superior gender, and their identity as men is defined through sexual ability and accomplishment. Poverty reinforces this violent and aggressive behaviour which men see nothing wrong in as they are only exercising their right based on the ideology of supremacy, clinging to previous positions of power. For men, sexual potency gives social potency, while for women, sexual modesty is what gives social value, and men and women engage in sexual relations for different reasons (Silberschmidt 2004).

In her 2003 article on male disempowerment- and sexuality in East Africa, Silberschmidt explains that men are expected to have sex regularly with their wife or permanent partner, plus with other casual or steadier partners. Abstinence is perceived harmful and against a man’s nature, while condoms are un-masculine and limit men’s pleasure. Women are expected to adjust to men’s desires and it is neither possible nor appropriate for a decent woman to control sexual activity. Hence, one can not stop the spread of HIV by giving women the responsibility alone. Silberschmidt argues that the fact that men hold on tight to old attitudes and definitions of masculinity based on hegemonic values and behaviour is a threat to their own as well as others’ health (Silberschmidt 2003).

Without referring to one particular place or country in Africa, Alexis (2003) states that boys are socialized into believing that they are the superior sex. They are given priority over their sisters at home, they receive more attention in school, boys get to stay longer in school and the community leaders are most often men. Boys learn that men and masculinity are more appreciated in their communities, and men are more powerful and more important than women. Men are supposed to be brave, courageous, adventurous, aggressive and strong. Simultaneously they learn to look at women as soft, gentle, talkative, caring, nurturing and affectionate. Boys are socialised to believe that it is unladylike to initiate sex or have sexual needs and wishes, which is why women must be persuaded or forced. Boys also learn that one can not trust women, and the availability of

birth control offers a woman some control over her own body, which raises issues of trust. Women are perceived to care most about relationships and to be not as easily aroused as men. Boys are taught that they need, and should want, more sexual activity than women do, and that they should initiate sex; they actually have a right to do it, as women tend to be passive, reluctant, hesitant and rejecting. In many cultures boys learn that girls' sexual desire and experiences are unimportant, while girls learn that boys' needs and experiences are important for their own economic survival. In general, girls learn and prepare themselves for satisfying men (Alexis 2003).

5.7.4 (Domestic) Violence

The UNAIDS report "Facing the future together" draws attention to the issues of marital rape and domestic violence, stating that marital rape is disturbingly common throughout southern Africa, with the reluctance of judicial and political authorities to consider it a crime being part of the problem. Judgements have declared that consent to sex is inherent in marriage; hence husbands can not rape their wives. Abuse is widespread and many women regard beating part of their daily lives. In studies from Malawi, Zambia and Zimbabwe, large numbers of women agreed that a husband was justified in beating his wife "if she argued with him, went out without his consent, neglected the children, burned the food, or refused to have sex" (UNAIDS 2004b: 16). Furthermore, violence increases women's vulnerability to HIV not only as a result of the violent act itself, but also due to the fact that sexual violence increases their likelihood of engaging in high-risk behaviour later. What is more, the use of rape and other forms of sexual violence is not only widespread; it is also widely accepted and approved of (UNAIDS 2004b).

In the Human Rights Watch report "Just die quietly: Domestic violence and women's vulnerability to HIV in Uganda", Karanja (2003) explains how the spread of HIV in Uganda happens in an environment where women are economically dependent on men and domestic violence is a part of everyday life, leaving women with no authority over their own sex lives or reproductive health. Ugandan men have absolute dominion in marital sexual relations as in most other areas of family life and society at large. It is believed that by saying "I do" women concede to sex whenever the husband wants it, and women have no cultural or legal power to neither refuse sex nor control safe sex. Marital

rape or forced sex is widespread, but since women think it is their duty to have sex with their husbands, they do not very often object. For many women it feels more dangerous to stop having sex with their husbands than to risk the infection or re-infection of HIV. The danger of re-infection is repeatedly mentioned here, but nowhere else, being the possibility for a person who is infected with HIV to be re-infected with the same strain of HIV or being infected with two different strains at the same time. In another Ugandan study, Luke (2003) found that both adolescent boys and girls thought rape to be justifiable in situations where the girl tried to get the material benefits from a relationship without giving sex in return.

According to Matsamura's study on domestic violence linked to HIV/AIDS, women in Uganda are still valued as property, and brutal attacks and marital rape has become a barrier in the fight against HIV/AIDS. She refers to the "Just die quietly"- study pointing out women's lack of authority to refuse sex or insist on condom use. Many women face verbal threats from their partners, and their bodies, labour and productive capacity are all controlled by their husbands. Matsamura reveals that domestic violence by many is considered a normal part of marriage, maybe even a sign of love, and women are taught to be subordinate and not to disobey their husband (Matsamura 2003).

Silberschmidt (2003) talks about Kenya and Tanzania where there is a widespread understanding that men need a lot of sex, perceived a biological fact, and men are polygamous by nature while women are monogamous. Violence and even rape are accepted ways of demonstrating masculinity and are used as tools for regaining control, social dignity and self respect. Sexual modesty gives social value to women, but not to men, and men's honour is dependent on their women's appropriate behaviour. Mulama (2003) points out that fear of violence from their spouses also prevent many women from accessing the necessary information about HIV/AIDS.

The media backgrounder "Violence against women and AIDS" [s.a.] also points out that violence against women increases female vulnerability to HIV. Because they fear violence, many women do not access HIV/AIDS information, they do not get tested or they disclose their HIV status, they do not access services to prevent mother-to child transmission and the fear prevents many from receiving treatment and counselling. Still, violence against women is widespread and often socially sanctioned or tolerated. A

Zambian study also revealed that only 11% of respondent women believed that a woman had the right to ask her husband to use a condom, even when she knew he was being unfaithful and HIV-positive (Violence against women [s.a.]: 2).

Writing about Africa in general, Leclerc (2001) states that not only is premarital- and extramarital sexual activity high, but so is also the rate of sexual violence. A woman suggesting condom use, refusing sex, curtailing a relationship, having another partner or being suspected of having another partner may all lead to beating, a violence which is often perceived a sign of affection. At the same time, sex is believed to be a part of the marriage "deal" which the husband can demand at any time. Also Umerah-Udezulu (2001) reports perceptions of rape in the form of intermarital coercive sexual relations as part of men's marital rights.

Violence against women, especially rape, is mentioned also by Sengendo [s.a.] as a major risk factor, and unemployment and deprivation among youth make them more likely to engage in risky behaviours. He presents seasonal commercial sex workers as one example, and being desperate for survival, they are in a weak bargaining position for safe sex.

From the late 1990s, attention has been paid to the position of men and their involvement in the transmission of HIV, as well as to gender-related violence and sexual abuse against women and children and their involvement in the spread (Akeroyd 2004). Akeroyd states that women are far more likely than men to have sexual intercourse forced on them; consequently women are at greater risk of infection. She also points out the belief that sex with a virgin will cure AIDS as a contributing factor to the extent of rape of young girls and even babies (2004).

5.7.5 Focus on Men

Baylies and Bujra (1995) start their paper by pointing out that in Africa HIV is largely transmitted through heterosexual sex. This takes place in an environment of gender inequality, and these authors claim that to control the AIDS epidemic, a transformation in gender relations is required, which can not happen without first recognizing the existing power relations and the embedded structure of male power. Without a change in male behaviour and response, women can not protect themselves.

Looking at the pre 1996 literature on causes and effects of HIV/AIDS, Akeroyd argues that what is needed above all is the empowerment of women, while pointing out that calls for men to restrict their number of sexual partners may actually worsen women's position further, as many women are dependent on what they get in exchange for sexual services. Akeroyd's stand is that the focus should rather be shifted towards gender relations of inequality, or even all the way to men alone. While women need to be empowered, men face de-powerment, which they have reason to fear, as giving women power in sexual matters may very well impact on other aspects of gendered relations as well. Akeroyd sums up that men may be the solution, but men are also the problem (Akeroyd 1996).

In Mbale, Uganda, women are not in a position to create a safe sexual environment for themselves, but Nossum points out that due to the expectations to and perceptions of what it implies to be a man; nor men are free to choose *one* sexual partner, safe sex or abstinence. While women are not in a position to initiate condoms, men believe that sex is better for women without condoms, and many men have a desire to satisfy their women's appetite. Nossum points at the need to focus on men and women together in prevention campaigns and development aid, as the two genders and their roles can not be regarded independent of each other (Nossum 2002).

Akeroyd (2004) argues that while women contract HIV at a faster rate than men due to physiological susceptibility, men have a greater number of sexual partners and she thus sees men as driving the epidemic. Also Kvam and Eskildsen (2002) call for a focus on men as men have more sexual partners than women do, thus men contribute stronger to the spread of HIV. The fact that men are also normally the ones to decide whether or not to use a condom, being the dominant part, is important here. Also Schoepf (1995) says that to reduce the amount of risky behaviour, the focus must be set on men, but concurrently also women need to realize the importance of and accept the use of condoms in risky relationships.

After presenting perceptions of male nature and culture, also Leclerc (2001) concludes that a focus on men and their attitudes and behaviours is needed. The editor of WIN News, where Leclerc's article was published, ads (in Editor's note) that African men need to drastically change their sexual activities and behaviour and points at the traditional attitude of treating women as property. In addition, he misses mentions of child marriage

and the bride price system in Leclerc's article, and he states that "Going to school is a huge hazard for girls who are raped both by their teachers and classmates quite aside from being easy prey for any man on the way to school" (Leclerc 2001: 3). He claims that a culture of rape is dominating all of Sub Saharan Africa while men are regarding it a right of manhood to have sex with any female they wish (Leclerc 2001).

In circumstances where men are losing their traditional control over women, most men do not welcome the general safe sex massages including sticking to one partner, and it is in this connection that Silberschmidt (2004) brings forward her main argument that "strategies to empower women and improve their deteriorating sexual and reproductive health are only meaningful if they are balanced against efforts to deal with men's increasingly frustrating situation" (Silberschmidt 2004: 245). She points out a need to pay attention to men and question the stereotypes of male domination and women's subordination which is prominent in current HIV/AIDS prevention efforts.

5.8 Fatalism

An important term in the study of culture and the spread of HIV in South East Africa is fatalism. Fatalism is the belief that life is pre-determined and that individuals are powerless to change what happens to them. Men and women seem to show two different faces of fatalism and different reasons not to protect themselves against HIV and use condoms. While women calculate what is worst, what is the lesser of the two evils having unprotected and often involuntary sex or facing the consequences of refusing one's partner, men gamble with unprotected sex with multiple partners, not wanting to think about potential consequences, rather enjoying the moment.

The most explicit expression of fatalism and what appears to be an ignorance towards ones own fatality, is men referring to the use of condoms by the metaphors of eating sweets with the wrapping paper on[69] or taking a shower wearing a raincoat[70]. Other idioms used are that you can not enjoy the taste of chewing gum if you do not remove its cover, and that you need to peel a banana in order to enjoy eating it (Lugalla et al 1999). Many find no justification for preventing their own pleasure since "we're dieing anyway", and if

[69] See among others Kyakuwa 2002
[70] See among others Obbo 1995

it is not HIV, it will be something else, with a number of mortal diseases and other death causes being an innate part of every day life. Some of Rugalema's respondents in Kenya and Tanzania moreover argued they would rather die happy than abstain from sex (Rugalema 2004).

Among Bauni and Jarabi's informants in Kenya, some argued that getting AIDS is like a road accident in the way that you can not stop a driver from driving because of the fear of an accident (Bauni and Jarabi 2000). Among the Basoga it was argued that one can not run away from AIDS, so why try? (Kyakuwa 2002) In Zambia it was also stated that avoiding AIDS is impossible because it is God's choice, and Ndubani (1998) argues that rather than encourage behavioural change, seeing many people with AIDS can actually be a source of fatalistic conceptions.

Silberschmidt's work among men in Kenya and Tanzania, an area with STDs and HIV rates ranging sky high, shows little consciousness about the risk of sexually transmitted infections (STIs) including HIV. An example given by an informant was the attitude that one can get hit by a bus tomorrow, but that does not stop one from going out, implying the unlikelness of getting hit (Silberschmidt 2003).

Among the Barabaig, illness is a culturally accepted notion of punishment. Being accustomed to suffering, for the Barabaig death and dying are parts of everyday experiences, and AIDS is only one of many perils (Blystad 1995).

From Zambia Dover (2001) reports the attitude being that one's time is up when God decides; hence there is no reason for taking protective actions. Akwara, Madise and Hinde (2003) report an equivalent fatalistic attitude towards AIDS from Kenya with people arguing that one does have to die of something.

Bergholdt Jensen, Information Officer in a Danish NGO working in Mozambique, sums up that the fatalistic vision of life in African societies some times make it difficult to change people's behaviour concerning HIV/AIDS. Kirsten Madsen, an HIV/AIDS adviser, explains that people often do not see themselves as having any option, nor personal responsibility. It is a common belief that it is God's will whether one gets AIDS or not, hence there is nothing one can do to have any influence on one's destiny. When people do not see how their own actions can have an influence on their lives, promoting

behavioural change is a considerable challenge. The harsh living conditions of people in poverty are also of importance in their fatalistic approach towards HIV/AIDS. It is argued in Bergholdt Jensen's article that when people know they can easily die from cholera or malaria, "HIV/AIDS is just seen as another unpreventable illness like the others" (Jensen 2004: 8. paragraph). Which disease you die from does not make much of a difference.

Fatalism is integrated in the cultural belief system. It can in part be traced back to experiences of being victim of failed institutions and corruption, and an overall scepticism towards foreign imposed rules and systems as well as towards western medicine and western values in general. Attitudes to, and perceptions of HIV, are hence parts of a larger fatalism of victimisation, of living and dieing in Africa. People's experience is that there is nothing one can do to change one's situation.

Life expectancy at birth is falling dramatically in the region, but that is not a number most people acknowledge or are even aware of. There is however a correlation between low life expectancy and fatalism; both are most pronounced in poor countries. Moreover, even though people are probably not aware of the actual numbers, they do of course notice that people around them are dying. There appears to be a lacking awareness as to how deadly HIV/AIDS actually is; either people are not fully aware of it or it is just not really dealt with. The traditional belief system is not equipped to deal with this new set of standards for what disease is, and the traditional means of protection against illness are no longer sufficient. This is furthermore in line with pre scientific perceptions and experiences of HIV/AIDS in the West.

Chapter 6

Concluding remarks

Seeing culture as a people's learned behaviour, their way of thinking, feeling and believing, it is remarkable that culture has not gotten more attention in the fight against HIV/AIDS. What has been attempted illustrated in this thesis is that culture is, and should be acknowledged as being, of cardinal importance in campaigns designed to halt the spread of HIV.

South East Africa holds a mind set very different from the Western regarding how people see HIV. One important aspect is the neglect, or lack of knowledge, to see HIV as a new and different kind of disease. My argument is that in order to understand people's perception of risk, to comprehend how good sex is defined, and to understand why people do not change their behaviour, even when they know what they are doing is risky, it is essential to take traditional cultural belief systems into account. Furthermore, the Catholicism practiced in this region is strictly patriarchal, with the concept of motherhood at its centre. Unfortunately this concept places women and mothers at particular risk by not permitting them to protect themselves. The combination of these two belief systems, the traditional and the religious, serves as a major obstacle to educating entire populations and especially young -and not so young- women. In many ways the two belief systems are quite distinct, but when it comes to gender relations and scepticism towards condom use, they tend to pull in the same direction: Away from prevention of births and of HIV.

In South East Africa women are the most vulnerable population due to cultural, religious and physiological factors. Hence, educating these women about sex is necessary, but insufficient. Women need both knowledge of how to protect themselves and the empowerment to do so. Girls and women need to be empowered and enabled to take control of their own lives. Furthermore, women are caught in a web of vulnerability, and

their perceptions of risk relating to HIV are not limited to their factual knowledge about passageways and probabilities. Just as significant are the risks faced by refusing sex or suggesting condom use: The risks of not giving pleasure to men and of being stigmatised as promiscuous.

Enhancing women's empowerment means a radical change in social relations, which seems necessary in order to achieve changes also in male sexual behaviour. At the same time people need to understand what HIV means for them as a community. It is my hope that by taking culture into account, the international community can help enable not only the most vulnerable, but also the South East African population in general, to protect and forestall themselves and future generations against the threat of HIV/AIDS.

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